

JOHN EASTMAN,
Plaintiff,
vs.
BROWN & WILLIAMSON TOBACCO CORP.,
individually and as successor by
merger to THE AMERICAN TOBACCO
COMPANY, a foreign corporation;
PHILIP MORRIS, INCORPORATED, a
foreign corporation,
Defendants.

BEFORE: HONORABLE ANTHONY RONDOLINO
PLACE: The Judicial Building
545 First Avenue North
St. Petersburg, Florida
DATE: Tuesday, March 25, 2003
TIME: 1:10 p.m. - 4:50 p.m.
REPORTED BY: TONYA H. MAGEE, RPR
Court Reporter and Notary Public
Sixth Judicial Circuit

TRIAL PROCEEDINGS

Pages 2733 - 2866

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1 *****
2 THE COURT: What's next?
3 MR. ACOSTA: Judge, the defense is going to
4 read their cross-examination of Dr. Back, and then
5 we're going to try to show some video, but the
6 sound is not very good. And on one of them, we're
7 going to show it for a couple of minutes, then I
8 was just going to freeze the picture and then read
9 the rest of it. And then on the other one, it --
10 it goes in and out, and so there might be a few
11 thing that they're difficult to hear and we'll try
12 to read some of it, if we have to. But otherwise,
13 we're going to play it through. And I just have to
14 let you know that the sound is terrible on it,
15 unlike the last one.
16 THE COURT: You should do it through the
17 manuscript.

18 MR. ACOSTA: Well, my theory was that
19 John Moss' blackberry was on and it was -- you
20 know, it was interfering with the -- the camera,
21 but --
22 MS. FAGGIANELLI: That's a new one.
23 MR. ACOSTA: -- I don't know for sure, because
24 it worked in the other video.
25 MR. LYDON: We weren't quite sure what the
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1 blackberry chips were.
2 MS. FAGGIANELLI: Now we know.
3 MR. ACOSTA: I just don't know. I don't know.
4 THE BAILIFF: You ready for the jury?
5 THE COURT: I am.
6 MS. FAGGIANELLI: Your Honor, would you
7 explain to the jury that we're just doing the
8 cross-examination of Dr. Back?
9 MR. CHRISTOPHER: They know through the video
10 before and now it's with me.
11 THE COURT: All right.
12 (The jury entered the courtroom, after which
13 the following proceedings transpired:)
14 THE BAILIFF: The jury is present and seated,
15 Your Honor.
16 THE COURT: Okay. Thank you, Sheriff.
17 Ladies and gentlemen, if you remember from
18 before lunch, you saw the video deposition
19 testimony of the physician. After lunch, now we're
20 going to be engaging in cross-examination, but to
21 speed things along, the editing process probably
22 works better this way. Instead of showing the
23 video of the answers to the questions given by the
24 witness, they are going to read those in the format
25 that we have done before. So at this time I guess
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1 Mr. Christopher is going to play the part of the
2 witness and the questions are asked directly from
3 the transcript of the deposition.
4 MR. CHRISTOPHER: Thank you, Your Honor.
5 (Whereupon, excerpts of the cross-examination
6 of the deposition testimony of Martin R. Back, M.D.
7 was read to the jury, with Ms. Faggianelli reading
8 the questions and Mr. Christopher reading the
9 answers, as follows:)
10 Q. Do you have some records available to you
11 sitting before you that would identify the exact
12 location of the abdominal aortic aneurysm, vis-a-vis
13 where it starts in the aorta and where it ends?
14 A. Yeah. In the first notes dated November 4th,
15 2002, there's mention made of a juxtarenal abdominal
16 aorta aneurysm, and that was to my interpretation of the
17 CT scan or the CT scan that was done to diagnose the
18 aneurism. What juxtarenal means is that the aneurysm
19 begins in the region right around the kidney arteries
20 that branch high in the abdominal region and make the
21 repair of the aneurysm somewhat more complex. His
22 aneurysm extended down into the end of the aorta, into
23 its branching site at the iliac arteries, and he had
24 evidence of atherosclerotic disease in the iliac
25 arteries on both sides.
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1 Q. Do you have a copy of the CT scan report upon
2 which you are relying when you made your assessment of
3 the location?

4 A. Not a copy of the CT report. The actual
5 films. And those are in my office at the Veterans
6 hospital, where I'm the chief of vascular up there.

7 Q. I'm going to show you one of the records from
8 the VA Hospital. It's the CT scan report dated
9 October 30th, 2002, and it's Bates number
10 200363.249.0087, and ask you whether this CT scan report
11 is consistent with what you just told us regarding the
12 location and extent of the abdominal aortic aneurysm.

13 A. Most importantly, the CT scan was obtained
14 fairly recently, October 30th, 2002, which is pertinent
15 to aneurysms which can change in size. So it's a fairly
16 recent CT scan. The description here is that the
17 aneurysm reaches a maximal dimension of 6.4 centimeters
18 in a segment of the aorta below the kidney arteries and
19 down toward the bifurcation or the branching site of the
20 aorta. The maximal dimension of the aorta at the level
21 of the superior mesenteric artery, by the description
22 here, is 4.3 centimeters, and that's consistent with my
23 finding. That's what makes it a juxtarenal aneurysm.
24 That is, the aorta doesn't come back to a normal
25 diameter at the level of the renal arteries. It is

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1 enlarged or widened.

2 (Whereupon, there was an interruption in the
3 reading of the deposition testimony, as follows:)

4 MS. FAGGIANELLI: Can we have the slide?

5 (Whereupon, the reading of the deposition
6 continued, as follows:)

7 Q. Because these curves in the anatomy are
8 somewhat obscured to laypersons, I brought with me a
9 picture that purports to show the aorta, and I'm going
10 to show this to you. And I've got a copy for counsel.
11 Let's put it on.

12 I want to ask you whether or not, number one,
13 do you think this is a reasonably accurate
14 representation of the aorta and other anatomical
15 structures nearby?

16 A. Yes, it is.

17 Q. Okay. Let me ask you another question. Since
18 you said that it's a reasonable representation, I didn't
19 want to cut you off, so go ahead and explain what it is
20 if you think you can add something further.

21 A. These drawings are made from cadaver
22 dissections and this shows relatively normal anatomy
23 related to the aorta; that is, a nonaneurysmal aorta.

24 Q. On this diagram, if I give you something to
25 mark with, can you identify -- oh, you already have

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1 something. Excellent.

2 Can you identify the level at which the
3 aneurysmal changes begin and the levels at which they
4 end? You can feel free to go ahead and write on there.
5 We'll March this as an exhibit.

6 A. His aneurysm begins at the level of and just
7 above the renal arteries. So I've drawn an arrow here
8 pertaining to the locations of the origins of the two

9 kidney arteries that come off to the right and to the
10 left and at the region where the superior mesenteric
11 artery is, which is the main artery going into the
12 intestines -- one of the main arteries going into the
13 intestines. His aneurysm extends down to the end area
14 of the aorta, which is called the bifurcation region.
15 His iliac arteries, which are beyond this branching
16 point of the aorta, these two iliac branches going to
17 both of the legs and also have some branches into the
18 deep pelvic area, showed heavy calcification consistent
19 with atherosclerosis, as described in the report and to
20 my -- and it's consistent with my interpretation.

21 Q. So the arrow you put on top here indicates
22 where the aneurysm started?

23 A. Where it begins.

24 Q. Where it begins. The arrow at what is call
25 the bifurcation where the aorta splits in two is where

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1 the aneurysmal changes ended but -- and below that you
2 saw some additional atherosclerotic changes
3 bilaterally --

4 A. Correct.

5 Q. -- is that fair to say?

6 A. Correct.

7 Q. Would you just initial that and date it. And
8 I will ask the court reporter to have that marked as
9 deposition Exhibit Number 1.

10 (Whereupon, there was an interruption in the
11 reading of the deposition testimony, as follows:)

12 MS. FAGGIANELLI: You can take the slide down.

13 Thank you.

14 (Whereupon, the reading of the deposition
15 continued, as follows:)

16 Q. I would like to ask you a few questions now
17 about Mr. Eastman's history and risk factors for
18 abdominal aortic aneurysms. Are you familiar with risk
19 factors in general for abdominal aortic aneurysms?

20 A. Yes.

21 Q. Were you familiar with Mr. Eastman's history
22 of radiation therapy for treatment of testicular of
23 seminoma in the late 1960s?

24 A. No, I was not.

25 Q. Are you familiar as you sit here today with

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1 radiation therapy protocol for treatment of testicular
2 seminoma circa. 1960 to '65?

3 A. Not in that era, no.

4 Q. What are the sources that you would want to
5 look at to determine the radiation protocol given to
6 patients for testicular seminoma in the early 1960s?

7 A. A textbook that a -- or a textbook that was
8 available at that time on oncologic procedures and
9 management with radiation therapy.

10 Q. I'm going to tender to you this document and
11 ask that you identify it, if you can.

12 A. Textbook of Radiotherapy, authored by
13 Gilbert Fletcher, M.D.

14 Q. And on the next page?

15 A. Copy from M.D. Anderson Hospital.

16 Q. On the next page, I think it identifies the
17 year that this book was initially published?

18 A. 1967.
19 Q. I actually see a copyright date of 1966; is
20 that correct?
21 A. 1966 at the bottom, correct.
22 Q. Can you turn to page 527 of that textbook
23 chapter. I'm going to ask you a couple of questions
24 about that. But is this the kind of radiotherapy
25 textbook from the '60s that you would find to be a

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1 reliable resource for determining what the treatment
2 fields were for testicular seminoma in the 1960s?
3 A. Yes.
4 Q. So do you believe that a textbook published in
5 1966 with respect to radiotherapy would be a reasonable
6 indication of what the treatment protocol would have
7 been for testicular seminoma in 1961 and 1962?
8 A. Appropriate, yes.
9 Q. And can you, in terms that we can understand
10 as nonphysicians, describe what this diagram in the
11 lower left-hand corner of page 527 is?
12 A. The radiation fields would include the middle
13 portion of the abdomen or stomach area, extending up
14 into the very lowest portion of the chest and extending
15 down to adjacent to the groin regions or the pelvic
16 regions.
17 Q. And would patients, based upon these radiation
18 fields identified in the diagram, receive radiation
19 given both to the front of their body and to the back of
20 the body?
21 A. Correct.
22 Q. In this diagram, does it identify whether or
23 not treatment fields set up there are for left versus
24 right side in testicular seminoma?
25 A. In figure 11, dash, 12, this is pertinent to a
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1 seminoma of the left testes so that the radiation portal
2 deviates toward the left pelvic region.
3 Q. Does the radiation field in the abdominal
4 midline also deviate slightly so that the center of the
5 field travels just to the left of the spine?
6 A. Correct.
7 Q. Is that also where the aorta travels in the
8 abdomen cavity, just to the left of the spine?
9 A. Just to the left of the spine, correct.
10 Q. Having had the opportunity to review the
11 Textbook of Radiotherapy chapter on the treatment of
12 testicular seminoma published in 1966, is that a
13 reliable resource that you would consider reasonable for
14 determining the treatment protocol for testicular
15 seminoma?
16 A. Yes, at that time.
17 Q. I would like to turn our attention to the
18 abdominal aorta more particularly. I think at the last
19 deposition you gave a nice description of what is an
20 aneurysm, and I would just like to ask you a few
21 follow-up questions that relate to the anatomy of the
22 aorta. And in particular, can you tell how -- what
23 how -- what makes up the wall of the aorta, the wall of
24 that vessel?
25 A. Three different layers, an inner layer that is
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1 the inner lining that's in contact with blood flow, the
2 intima, does not have much strengths related to it, but
3 regulates clotting mechanisms at its surface.

4 The second layer is the media, which is
5 primarily a muscle layer that provides some strength,
6 but also gives the ability for the vessel to change its
7 width or diameter by contracting or relaxing the
8 muscles?

9 And finally, the outer layer, called the
10 adventitia, which is primarily the strength layer in the
11 aorta and is composed primarily of fibrous tissue which
12 is -- which provides the strength. It does not have
13 much activity in terms of clotting mechanisms and it
14 does not necessarily contract and change the width of
15 the vessel.

16 Q. So there are three layers to the wall of the
17 vessel?

18 A. Correct.

19 Q. What is the vaso vasorum?

20 A. Those are very small, microscopic blood
21 vessels within the wall of these larger blood vessels
22 that provide nutrients to the wall of the vessel.

23 Q. Where is this group of vessels that provide
24 nutrients in the abdominal aorta?

25 A. It's primarily in the outer layers in most
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1 vessels. The infrarenal aorta that is below the renal
2 arteries has a relative posity of vaso vasorum.

3 (Whereupon, there was an interruption in the
4 reading of the deposition testimony, as follows:)

5 MS. FAGGIANELLI: And could I have the slide,
6 please?

7 (Whereupon, the reading of the deposition
8 continued, as follows:)

9 Q. Turning your attention to the deposition
10 exhibit that you marked at the time of your first
11 deposition, I've gotten some different colors today,
12 first of all, in case you want to use them. Can you
13 identify in this exhibit the structures that were the
14 target of the radiation treatment for seminoma?

15 A. Roughly those boxes from that figure that you
16 showed me earlier that would involve this area and
17 potentially down here into the groin or deep pelvic
18 region.

19 Q. And you've marked those areas in red on this
20 diagram?

21 A. Correct.

22 Q. Within those fields was there a particular
23 part of the anatomy that the seminoma was suspected to
24 be in that they were trying to treat?

25 A. Within the lymph nodes that are adjacent to
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1 the aorta and the pelvic arteries.

2 Q. Can you use a green marker and just draw an
3 arrow to the peri-aortic lymph nodes?

4 A. Some of these lymph nodes here we can draw
5 arrows or we can circle the lymph nodes that are shown
6 on the diagram themselves.

7 Q. Okay. You've identified -- and those would be
8 on both sides of the aorta, correct?

9 A. They are on both sides of the aorta. More so
10 here between the aorta and the vena cava.
11 Q. Can you just label that, I guess, just pull
12 that arrow out and just label the --
13 A. Let's call it LN for lymph node.
14 Q. Maybe with the red do a similar label just for
15 later on that identifies the irradiation.
16 A. Let's call that XRT for irradiation.
17 Q. Okay. The per -- I'm sorry, where do the
18 peri-aortic lymph nodes lie with respect to these
19 vessels that are called vaso vasorum?
20 A. They are outside of them. Outside of the
21 aorta, but adjacent to them.
22 Q. What does adjacent mean?
23 A. Within several centimeters of distance.
24 Q. All right. Having had the opportunity to
25 review the CT scan today, can you tell me, based upon

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1 what you previously marked in deposition Exhibit Number
2 1, with this arrow as being the area where the aneurysm
3 began, whether that remains accurate or whether that
4 needs to be revised at all?
5 A. No, it's accurate. It's at the level of
6 the -- adjacent to the superior mesenteric artery and
7 the celiac artery.
8 Q. Can you just label that arrow as something to
9 indicate that that's where the aneurysm begins?
10 A. AAA is a marking for aneurysm.
11 Q. And then can you identify or just confirm
12 again, I guess, that you had put an arrow here at the
13 bifurcation to indicate where the aneurysm,
14 approximately where it ended; is that correct?
15 A. Yeah. We'll call the top one B, for
16 beginning, and the bottom AAA, slash, E, for ending.
17 Q. Okay. I would like to ask you a couple of
18 questions now about how the effects of irradiation --
19 (Whereupon, there was an interruption in the
20 reading of the deposition testimony, as follows:)
21 MS. FAGGIANELLI: I'm sorry.
22 (Whereupon, the reading of the deposition
23 continued, as follows:)
24 Q. -- (continuing) about the effects of
25 irradiation on vessels. Do you have any background and

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1 training with respect to the effects of irradiation on
2 vessels?
3 A. I have knowledge of it. I have not done any
4 specific research myself.
5 Q. What is the source of your knowledge?
6 A. Textbooks, published papers and peer-reviewed
7 journals.
8 Q. And is that a source of knowledge that's
9 commonly relied upon by physicians who practice in your
10 field?
11 A. Correct.
12 Q. Can irradiation of vessels cause trauma that
13 results in calcified changes?
14 A. It depend if you're specifying on the size of
15 the vessel being treated or the size of the effect of
16 the vessel that is being irradiated.
17 Q. What are the calcifications when you are

18 talking about what you see in vessels on CT scan?
19 A. Calcification is deposition of calcium similar
20 to the calcium deposits that occurs in bone that can
21 occur within a diseased artery. It's part of the
22 atherosclerotic process. It affects large arteries
23 only. That is arteries any smaller than a millimeter or
24 so don't tend to be affected by atherosclerosis and
25 calcification.

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1 Q. What's the size of the vaso vasorum, those
2 vessels in that network in the scale of all of the
3 vessels?
4 A. The smallest, microns. Microns are millions
5 of a meter. These are the smallest vessels.
6 Q. And based upon your knowledge of the effect of
7 irradiation on vessels, can irradiation damage small
8 vessels?
9 A. Yes, it can.
10 Q. What kinds of damage does irradiation cause to
11 small vessels?
12 A. It causes an inflammatory process to occur
13 within those vessels that lead to -- many times to
14 thrombosis and obliteration of those small vessels,
15 sometimes referred to as radiation-induced arteritis,
16 which just implies that there's inflammation in those
17 small vessels.
18 Q. Are there certain recognized consequences of
19 the obliteration of small vessel?
20 A. Yes, there is.
21 Q. What happens when small vessels are
22 obliterated?
23 A. An example of radiation to the pelvic region,
24 which also involves the blood vessels supplying the
25 intestines, is that you can get an obliteration of the

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1 blood vessels to those intestines resulting in
2 structures or scarring processes within those small
3 vessels that supply the wall of the intestines. So
4 that's evidence of damage to the organ supplied by the
5 small vessels.
6 Q. Are the vaso vasorum within this group of
7 small vessels that could be damaged by irradiation?
8 A. Yes, they could potentially be.
9 Q. And would the tissues that receive nutrients
10 and oxygen from the vaso vasorum, are those within the
11 tissues that could suffer damage from the obliteration
12 of the vaso vasorum?
13 A. Correct.
14 Q. How many patients have you treated who had
15 irradiation of the fields you've indicated in this
16 exhibit in the early 1960s?
17 A. Not many.
18 Q. Can you recall any others?
19 A. Not specifically, but we've had many patients
20 with concomitant malignancies, or malignancies, cancers
21 in the past involving the intraabdominal region, some
22 treated with radiation and not specifically with
23 aneurysms, but with associated atherosclerotic occlusive
24 disease.
25 Q. Were those patients that you're recalling

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1 treated with radiation in the early '60s?

2 A. I couldn't say specifically.

3 Q. In the patients that you have treated in your
4 experience with a history of irradiation to vessels that
5 have atherosclerotic changes, do you see a particular
6 pattern of distribution of those changes in the
7 irradiated part of the vessel versus the nonirradiated
8 part of the vessel?

9 A. The atherosclerotic process can be
10 accelerated; however, those patients may have other risk
11 factors for atherosclerosis as well.

12 Q. Is infertility one of the side effects that
13 you know about based upon your knowledge of radiation
14 therapy side effects and its effect on the body from
15 your medical training?

16 A. It is potentially, as is chemotherapy.

17 Q. I would like to move on and talk a little bit
18 about heredity as a risk factor for abdominal aortic
19 aneurysm. Is that something that you studied during the
20 course of your training?

21 A. Correct.

22 Q. Has that a developing field of particular
23 interest in the field of vascular surgery in the last
24 decade?

25 A. It has.

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1 Q. Why is that?

2 A. It was initially observed that approximately
3 one in five aneurysms seem to occur within families;
4 that is, that there were other relatives, blood
5 relatives within the family that had developed
6 aneurysms. So there's an ongoing surgery for the --
7 what exactly are those genes specific for passing on
8 hereditarily the predisposition to aneurysms. That has
9 not been identified as of yet. And it may be multiple
10 genes, not a single gene.

11 Q. Has that body of research resulted in any
12 screening programs for people who have relatives with
13 aneurysms?

14 A. It has.

15 Q. What are the nature of those screening
16 programs?

17 A. General recommendation followed by our
18 university practices and recommended to other primary
19 care physicians is an ultrasound being performed of the
20 abdominal aorta, again, the most common site for an
21 aneurysm to form, in first-degree relatives over age of
22 50, with potentially repeating the ultrasound study
23 several -- five years later or so in patients not found
24 to have an aneurysm initially.

25 Q. Has the research into heredity also been tied
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1 to certain research regarding pathological changes in
2 the wall of the aorta associated with those people that
3 develop aneurysms versus people that don't?

4 A. There are certainly accepted and acknowledged
5 changes in the arterial wall that is degeneration of the
6 media and the adventitia, weakening of the all,
7 structural weakening, as well as evidence of the
8 weakening process based upon different proteins or

9 chemicals that can be sampled within the blood in
10 patients who have aneurysms versus patients who don't
11 have aneurysms.
12 Q. Is age a risk factor for the development of an
13 aneurysm?
14 A. Yes.
15 Q. And what age has been associated with the
16 increased risk of aneurysm?
17 A. The peak incidence of aneurysms, that is age
18 at which patients are most likely to develop an
19 aneurysm, is in the range of 70 to 75 years of age.
20 Aneurysms can occur earlier, but typically not before 50
21 years of age. And they can occur in 80 years old or
22 older, but less commonly so.
23 Q. Is gender considered to be a risk factor for
24 development of aneurysms?
25 A. For abdominal aortic aneurysms, males

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1 outnumber females five to one.
2 Q. Are there a long list of theoretical
3 contributors to abdominal aortic aneurysms that are
4 still being studied?
5 A. Yes, there are.
6 Q. And what are those?
7 A. Again, the variant of atherosclerosis is the
8 degenerative process that occurs in the outer wall may
9 have some other stimulators that are not known. There
10 are hemodynamics or flow-related phenomenon from the
11 inside of the abdominal aorta that may predispose it to
12 dilation because of decelerative or slowing down of
13 blood flow that can occur in the abdominal aorta,
14 although there's -- those are theories and are not
15 necessarily supported by causal relationships.
16 Q. Is it fair to say that the mechanism, the
17 specific mechanism by which atherosclerosis is
18 considered to ultimately lead to the development of an
19 aneurysm is still theoretical and subject to further
20 scientific review?
21 A. That's a fair assessment, yes.
22 Q. Are you familiar with the work of Dr. Tilson
23 on heredity?
24 A. I am.
25 Q. Who is Dr. Tilson?

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1 A. He's a professor of vascular surgery,
2 professor of surgery. He's at a New York hospital, I
3 believe, New York Columbia. He's published extensively
4 on aneurysms and associations with hereditary factors.
5 Q. Has there been any consensus developed with
6 respect to the role of heredity among vascular surgeons
7 based upon the work of Dr. Tilson and others that have
8 followed that research?
9 A. That is that there may be some specific genes
10 related to the development of aneurysms, yes.
11 Q. In the patients that you've treated who are
12 nonsmokers but who have aneurysms, do you have a theory
13 in that group of people as to what caused their
14 aneurysms?
15 A. I don't have a theory. Again, there may be
16 familial relationship. The other acknowledged risk
17 factors potentially for aneurysms are high blood

18 pressure in approximately 75 percent of these patients,
19 again, overlapping the atherosclerotic population.

20 Q. I've just got a couple more questions, and
21 they relate to Mr. Eastman's CT scan over there.

22 I guess I would like to direct your attention
23 to three segments of the aorta in Mr. Eastman, the first
24 segment being above the diaphragm, and ask you just
25 generally if you can characterize the nature and extent

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1 of any changes that are -- or calcifications that you
2 can see there?

3 A. He has some calcifications of the descending
4 thoracic aorta that's in the lowermost portion of the
5 chest cavity. That's where the CT's scarred, so we
6 don't get the benefit of the entire aorta all the way up
7 into the chest. But there is some calcification in that
8 level. Because intravenous contrast was not used in
9 this study, we also don't get any really details about
10 the intimal disease process or clot distribution within
11 the aorta itself, which would give you an indication as
12 to the amount of disease in the wall.

13 And the last thing you can see from the plane
14 film here is that his aorta we would describe as
15 relatively tortuous. The atherosclerotic -- or the
16 aneurysmal process is one associated with both dilation
17 of the vessels and elongation, so it's got some -- it's
18 got some tortuosity to it.

19 Q. With respect to the calcified changes above
20 the diaphragm, do they go -- are they completely
21 circumferential?

22 A. They are noncircumferential or scattered.

23 Q. Kind of sporadic Dick?

24 A. Sporadic.

25 Q. Can you compare or contrast in general the

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1 nature of the calcific changes below the diaphragm
2 versus those above?

3 A. Below the diaphragm there's much more
4 extensive calcification in the wall of the aorta than
5 there is above.

6 Q. Based upon your experience in the patients in
7 the population that you've treated, can you put the
8 changes you see in Mr. Eastman's aorta with respect to
9 the extent of those calcifications that you see on a
10 spectrum among all the patients that you've seen during
11 the course of your career?

12 A. Probably one in ten aneurysms have extensive
13 calcifications associated with it. He's in the upper
14 tenth percentile.

15 Q. The high end?

16 A. The high end in terms of amount of calcium.

17 Q. Is there anything, any positive finding that
18 you've seen in Mr. Eastman's medical records outside of
19 the field of this CT scan that identifies significant
20 diffuse peripheral vascular disease or atherosclerotic
21 changes?

22 A. It doesn't appear to be documented. I'm not
23 aware of it.

24 Q. So as you sit here today, the only location
25 that you can state with reasonable medical probability

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1 that Mr. Eastman has significant atherosclerotic changes
2 based upon the medical evidence is in the distribution
3 that is identified on Exhibit Number 1 to the initial
4 deposition; is that correct?

5 A. Correct.

6 Q. Do you recall what Mr. Eastman's reason was
7 for wanting to defer surgery?

8 A. To continue the court proceedings relating to
9 this case.

10 Q. Do you recall any specifics with respect to
11 that conversation?

12 A. Specifics being that it was important for him
13 to continue these court proceedings, that he -- that
14 could not be delayed, according to him. If he was to
15 have his aneurysm repair, that he wanted to complete the
16 court interactions and then proceed with the repair of
17 his aneurysm.

18 Q. Can you characterize for me the level of
19 urgency that you communicated to him with respect to the
20 need to definitely treat his aneurysm and whether
21 further delay would change the risks of that procedure?

22 A. The large size of his aneurysm is a risk, has
23 a fairly high risk of rupture associated with it. The
24 severity of his obstructive disease in his lungs also
25 would predict a higher risk of rupture related to -- in

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1 addition to the size of the aneurysm.

2 I stated to him that I thought he was at a
3 very high risk of rupture within the coming months, in
4 fact, especially if he had delayed that. And I -- this
5 statement here is that what was transcribed was a 25
6 percent risk of rupture within the ensuing months, you
7 know, and that his chances of getting through this
8 operation were optimal only under elective conditions.

9 It this was an emergency situation, and he
10 ruptured his aneurysm, I think that his chance of
11 survival of any emergency procedure would be so low that
12 it would not be worth undertaking.

13 So that -- so that it would be somewhat risky
14 to wait getting the aneurysm fixed when we thought he
15 was in as optimal condition as could be from his lung
16 standpoint and that any rupture of the aneurysm during
17 that ensuing period of time would probably not be
18 addressed with surgical intervention. He would be
19 allowed to die.

20 Q. Did you approve of his decision to delay
21 surgery?

22 A. I agreed with it, but informed him of the
23 risks associated with it.

24 (Whereupon, the reading of the deposition
25 concluded, and the following proceedings

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1 transpired:)

2 MS. FAGGIANELLI: That's all, Your Honor.

3 THE COURT: All right. That completes the
4 testimony of the doctor. What's next?

5 MR. ACOSTA: Your Honor, at this time the
6 Plaintiffs would like to try to play the deposition
7 of Dr. Tinsley. It has very bad sound in it, and
8 so eventually we'll have to stop it and read from

9 thereon.
10 THE COURT: Okay.
11 MR. ACOSTA: This is -- this is the deposition
12 Dr. Steven B. Tinsley, M.D., taken February 5th,
13 2003.
14 (Whereupon, an excerpt of the videotaped
15 deposition testimony of Steven B. Tinsley, M.D.,
16 was played to the jury, as follows:)
17 BY MR. MOSS:
18 Q. Could you state your name for the record?
19 A. Steven B. Tinsley.
20 (Whereupon, there was an interruption in the
21 playing of the videotaped testimony.)
22 Q. Could you state your name for the record?
23 A. Steven B. Tinsley.
24 (Whereupon, there was an interruption in the
25 playing of the videotaped testimony.)
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1 Q. Could you state your name for the record?
2 A. Steven B. Tinsley.
3 Q. Can you identify the records that you've
4 brought with you? What do they include?
5 A. They include my initial evaluation of
6 Mr. Eastman when I saw him in the emergency room on June
7 10th, 1995. They include a discharge summary of when he
8 was discharged from the hospital. There's an ER
9 physician's report here from when he was admitted to the
10 hospital. There's two office visits here from when I
11 saw him in follow-up from the hospital.
12 There's an EKG. And then there's some
13 administrative materials including the bill that's here,
14 the billing from them, including information as far as
15 regarding addressing -- addresses and billing
16 information, how to contact the patient. There's a
17 few -- there are a few copies of prescriptions here, also.
18 Q. All right. And prior to the deposition today,
19 did you have an opportunity to review your office chart?
20 A. Yes.
21 Q. What is your specialty?
22 A. I do -- I have a specialty in internal
23 medicine, and I also have a subspecialty in pulmonary
24 and critical care medicine.
25 Q. What do you do in your capacity as an internal
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1 medicine physician?
2 A. I care for people's medical -- general medical
3 conditions, which can include pulmonary disease but
4 include heart disease, diabetes, high blood pressure,
5 preventive testing.
6 Q. Do you treat only adults, or do you treat
7 children as well?
8 A. Only adults.
9 Q. Can you describe for me the percentage of
10 patients you see that come to you in your capacity as a
11 primary care physician or an internist as opposed to
12 those who are seeking your care in your capacity as a
13 pulmonologist?
14 A. Probably approximately 55 percent as internal
15 medicine and about 45 percent as pulmonary.
16 Q. Are you board certified in any field?
17 A. I'm board certified in internal medicine. My

18 board certification in pulmonary medicine has expired a
19 couple years ago. But I was boarded at one point.
20 Q. Is pulmonology one of the fields these days
21 that requires periodic recertification?
22 A. Yes, it is.
23 Q. How frequently does that specialty require
24 recertification?
25 A. Every ten years.

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1 Q. When were you last board certified in
2 pulmonary medicine?
3 A. 1990.
4 Q. When were you certified -- board certified in
5 internal medicine?
6 A. I believe I was board certified in internal
7 medicine, I believe it was 19- -- I believe it was 1988.
8 Q. Where did you attend medical school?
9 A. I went to medical college of Virginia,
10 Richmond, Virginia.
11 Q. And what years did you attend medical college
12 in Virginia?
13 A. 1981 to 1985.
14 Q. Based upon your review of the records today,
15 can you tell me the date that you first saw
16 Mr. Eastman --

17 (Whereupon, there was an interruption in the
18 playing of the videotaped deposition testimony, and
19 a conference was held outside of the hearing of the
20 jury and the court reporter, after which the
21 following proceedings transpired:)

22 THE COURT: Folks, we're going to go into
23 reading the deposition at this time because the
24 audio gets even worse. Mr. Denson is doing the
25 answers and Mr. Acosta is doing the questions. Mr.

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1 Denson will have a chance to see what it looks like
2 from the witness stand.

3 (Whereupon, excerpts of the deposition
4 testimony of Steven B. Tinsley, M.D. was read to
5 the jury, with Mr. Acosta reading the questions and
6 Mr. Denson reading the answers, as follows:)

7 Q. As a general medical student before the time
8 period that you decided to specialize in pulmonary care
9 later on, what did you learn about the relationship
10 between smoking and health?

11 A. Smoking, generally speaking, had an adverse
12 impact on health.

13 Q. What did you do in the years following the
14 your graduation from medical school to pursue further
15 training?

16 A. I did an internship and residency in internal
17 medicine at Shands Hospital, University of Florida, and
18 then I did my pulmonary fellowship at Shands Hospital,
19 University of Florida.

20 Q. What year did you complete your pulmonary
21 fellowship?

22 A. 1990.

23 Q. So having completed your fellowship, you've
24 been in the Tampa, St. Pete and Clearwater area, you
25 were there between 1990 and 1995, correct?

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1 A. Right, correct.

2 Q. During that time period did you become
3 familiar with the practices of your peers in talking
4 with patients about smoking and health?

5 A. Yes.

6 Q. And was it your understanding that physicians
7 similar to yourself routinely spoke to patients about
8 smoking and health?

9 A. The majority of the physicians, yes, would
10 discuss with the patients the relationship between
11 smoking and health.

12 Q. Would you offer any further advice to the
13 patients who came to you with a smoking history in those
14 years between 1990 and 1995 in addition to telling them
15 about the relationships between smoking and health?

16 A. I would -- I would have a general discussion
17 about the relationships between smoking and health and
18 would oftentimes advise them to reduce and discontinue
19 tobacco use if at all possible, and oftentimes would
20 discuss various strategies available to assist them if
21 that was their desire.

22 Q. If the patient communicated to you a desire to
23 quit smoking, what strategies and assistance would you
24 offer to them?

25 A. Well, I would discuss the support groups that
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1 are available. Various communities do have support
2 groups associated with hospitals, similar to like the
3 support groups you would say in Weight Watchers. There
4 are support groups available.

5 There are -- biofeedback can be taught. I
6 don't personally teach them, but I can always make a
7 referral to someone who would deal with that. More
8 recently we've had a various degree of tobacco --
9 nicotine-related products.

10 Q. I just want to make sure the record is clear.
11 I'm asking for -- I want you to be particular to the
12 time period I'm talking about, between 1990 and 1995.

13 So if you need to rephrase your answer in any
14 way up to this point, then please let me know. But in
15 this time periods between 1990 an 1995.

16 A. I'm not certain when -- actually, yes, I'm
17 certain there were nicotine products available as far as
18 Nicorette gum was available, and I believe it was around
19 that time that the patches start becoming widely
20 available as an assist to break the habit of tobacco
21 use. I would also offer anxiolytics to patients to
22 assist them in their discontinuation of tobacco use.

23 Q. Based upon your review of the records today,
24 can you tell me the date that you first saw Mr. Eastman,
25 the plaintiff in this case?

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1 A. The first time I saw him on was on June 10th,
2 '95.

3 Q. Based upon your review of the office chart you
4 have there, is it your understanding that Mr. Eastman
5 presented to the emergency room on June 10th, 1995 and
6 that you were called in as a consultant to participate
7 in his care?

8 A. He did present on June 10th, '95 to the

9 emergency room, and I was called to the -- be the
10 admitting physician for him.
11 MR. MOSS: Why don't we go ahead and have the
12 hospital record marked as an exhibit so that
13 Dr. Tinsley can review it and we can be talking
14 about the same thing. Because these have Bates
15 numbers on them, it will be easier for the record.
16 Q. Sir, I'm tendering to you what is going to be
17 marked as Exhibit Number 2 to your deposition. Can you
18 identify that for the record?
19 A. It looks like the inpatient record of
20 Mr. Eastman during his hospitalization from June 10th,
21 '95 to June 20th, '95.
22 Q. Does it appear to be a complete copy of the
23 hospital record from that admission from the Morton
24 Plant Hospital?
25 A. It appears to be, yes.

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1 Q. Can you identify in there the emergency room
2 sheet that would reflect Mr. Eastman's condition upon
3 presentation to the hospital?
4 A. There is a dictated assessment from the
5 emergency room physician and there's an actual ER sheet
6 which is the form generated there in the emergency room,
7 yes.
8 Q. Okay. Let's -- if we can, let's turn to that
9 page 17, the emergency room physician's dictated report.
10 Based upon -- and just, as I said before, if
11 you feel more comfortable reviewing the handwritten
12 sheet that you know that you would have reviewed when
13 you came to the hospital in conjunction with that, just
14 so you know you're talking about something that would
15 have been available to you when you first saw the
16 patient, please do so.
17 So based upon the records that were available
18 to you when you undertook Mr. Eastman's care, what did
19 you know about his history?
20 A. Well, again, you do review the records, but
21 you also go discuss it in detail with the patient
22 itself. Are you talking about my complete ER evaluation
23 or just the records that were available to me?
24 Q. Well, I don't want us to get bogged down in
25 which records were available to you and which weren't.

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1 I just want to know what you assessed, what you
2 considered when you first saw the patient.
3 And if the easiest thing to do is to look at
4 your dictated consultant report, then we can just go
5 there.
6 A. No, the concern was that he may have had
7 pneumonia. There was concerns there may be what we call
8 an early lower lobe -- right lower lobe infiltrate. And
9 we knew that he was hypoxic, he had low oxygen levels
10 and was requiring supplemental oxygen.
11 The other concerns were the infectious
12 process. Given his history of tobacco use, he may have
13 had underlying obstructive pulmonary disease that the
14 infectious process may be exacerbating and continuing --
15 and contributing to his overlying -- his underlying
16 medical status that required his hospitalizations.
17 Q. What contributed to your diagnosis of

18 pneumonia?
19 A. He had a low-grade temperature, a temperature
20 of 100.3, which is low grade. He had a slightly
21 elevated white count. He had low oxygen levels. The
22 suggestion of an infiltrate in his right lower lobe. He
23 had a productive cough of purulent phlegm and he had
24 physical exam findings that were suggestive of
25 pneumonia, which would be what we call rales in the

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1 right base. And the combination of the clinical picture
2 led to a strong suspicion of pneumonia.

3 Q. In lay terms, what is the pneumonia?

4 A. Pneumonia is an infection of the lower
5 respiratory tract, of the actual infection within the
6 oxygen exchange units in the lung.

7 Q. Based upon what you see here with respect to
8 the lab values you've already described, did you have a
9 believe then or now as to whether or not the pneumonia
10 that was diagnosed was more likely viral or bacterial?

11 A. The suspicion was bacterial.

12 Q. Is there any difference in terms of the
13 clinical significance from a pulmonary standpoint to a
14 viral versus a bacterial pneumonia?

15 A. The biggest difference is that a bacterial
16 pneumonia will respond to antibiotic therapy and viral
17 pneumonia will not. It will have to run its course.

18 Q. In terms of what's actually going on in the
19 oxygen exchange part of the lung, is there something
20 that's different in a viral pneumonia versus a bacterial
21 pneumonia?

22 A. The biggest difference is often viral
23 pneumonias -- these are just tendencies, not a hundred
24 percent blanket in all patients -- but the tendencies
25 are viral pneumonias can typically be more diffuse, can

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1 affect larger segments of the lung, whereas bacterial
2 pneumonias are often more focal, involving more segments
3 of the lung rather than diffuse patterns.

4 Q. How do you differentiate a viral pneumonia
5 from a bacterial pneumonia in a clinical setting such as
6 this?

7 A. Generally speaking, viral pneumonias tend --
8 the coughs tend not to produce phlegm, they tend to be a
9 dry, nonproductive cough. That's one of the biggest
10 differences.

11 In the differential of the white counts, you
12 can at times see more of a lymphocytosis. Lymphocytes
13 will be higher. Whereas in the bacterial, you'll see an
14 elevation of the segs or the polys, which tend to
15 indicate more bacterial.

16 Q. What did you see in the labs in this case?

17 A. Predominantly an elevation of the segs and
18 that his lymphocytes were actually depressed. So the
19 clinical presentation and the laboratory values were
20 more suggestive of a bacterial pneumonia than a viral
21 pneumonia.

22 Q. Is it possible that nonetheless that it was a
23 viral pneumonia? Can they be ambiguous sometimes?

24 A. Yes, they can.

25 Q. Was it possible to absolutely rule out a viral

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1 pneumonia in this case?

2 A. In this case, no. The only definitive way to
3 make a diagnosis of a viral pneumonia, even though we
4 can have overwhelming evidence, and we seldom ever do
5 that is actually do with a lung biopsy to see the viral
6 inclusion within the cells itself. And we almost never
7 do that.

8 Q. So even a viral pneumonia can also present
9 with a patient with a productive cough?

10 A. Depends on -- depend on what the patients
11 underlying disease status is. The viruses sometimes can
12 lead to irritation in the airways, which can lead to
13 mucous production, so yes.

14 Q. In Mr. Eastman's presentation on June 10th,
15 1995, his temperature was 100.3, correct?

16 A. Correct.

17 Q. Would you sometimes expect a bacterial
18 pneumonia to present with a higher temperature?

19 A. Bacterial and viral pneumonias can present
20 from anything to low-grade temperature to -- anything
21 from low-grade temperatures, hypothermia, all the way up
22 to very high spiking temperatures. Depends on what
23 stage you catch it at and the virulence of the organism
24 that is actually involved.

25 Q. Was Mr. Eastman's white count of 11,400 only

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1 slightly elevated?

2 A. Slightly elevated.

3 Q. Would that suggest more likely a bacterial or
4 a viral infection, or is it ambiguous?

5 A. It's ambiguous.

6 Q. In the case such as Mr. Eastman's, are you
7 prescribing antibiotics kind of in the dark, you're
8 hoping that if the patient gets better with the
9 antibiotics quickly that would suggest to you that it
10 was bacterial?

11 A. There are times in which a response to
12 antibiotics can be highly suggestive of bacterial
13 process. That does not always indicate -- the rate of
14 the response does not necessary indicate bacterial
15 versus viral.

16 With severe pneumonias or with people with
17 underlying lung disease, their symptoms can be more
18 protracted. And also it depends on if you've made the
19 right choice of antibiotics.

20 You never have culture results or anything
21 back like that at the time you choose antibiotics. You
22 choose antibiotics based upon what you think the most
23 likely causative organism would be, and sometimes you're
24 wrong.

25 Q. How long had Mr. Eastman been suffering

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1 symptoms before he presented to the hospital on June
2 10th, 1995?

3 A. Two weeks.

4 Q. During that two-week period of time, what
5 would be going on in his lungs?

6 A. It depends on the exact cause. Again, you
7 want me to restrict just to pneumonia?

8 Q. Based upon Mr. Eastman's -- yeah, with respect

9 to pneumonia.

10 A. Okay. First off, many bacterial pneumonia can
11 be what we call post viral, so that sometimes people
12 start off -- start off with a viral upper respiratory
13 tract infection that weakens your -- weakens your
14 defenses such that you can become -- such that you can
15 then become superimposed with a bacterial pneumonia?

16 The durations of the symptoms is generally
17 again -- if pneumonia is the only causative problem, is
18 generally against a viral syndrome because viral
19 syndromes are usually self-limited and would have
20 resolved before a two-week period.

21 Some of the exceptions you may see is
22 specifically in Mr. Eastman's case when he does have
23 some underlying lung disease where a viral syndrome can
24 start an inflammatory process as in chronic obstructive
25 pulmonary disease, and despite the clearing of the

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1 virus, you still have the results of the inflammation
2 and have to treat the underlying disease process, which
3 would be the chronic obstructive pulmonary disease,
4 before a patient would have resolution of the symptoms?

5 So the time period would make you be somewhat
6 less suspicious of viral process at the time that he was
7 admitted, but not to say the viral process may not have
8 started it.

9 When a person with underlying lung disease
10 first gets the infections, sometimes you can deal with
11 the infections effectively and not exacerbate the
12 underlying lung disease. It is a very common -- but it
13 very commonly is the inflammation of a viral or a
14 bacterial process which will set up a vicious cycling of
15 inflammation, mucous secretion and reinfection of the
16 mucous to cause further inflammation of the lungs which
17 leads to edema of the walls, secretion of mucous to plug
18 the airways, and spasm of the muscles around the airways
19 causing asthma-like attacks.

20 If it is truly pneumonia, the process involved
21 includes inflammatory exudates and secretions, not only
22 of the airways itself, but will actually involve the
23 alveoli, the gas exchange units of the lungs themselves,
24 and will cause what we call a consolidation picture
25 where you have proteinaceous material, influx of

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1 leukocytes in an attempt to fight off the bacterial or
2 the infectious process.

3 And the recruitment of leukocytes in the
4 process of pneumonia can, in someone who has underlying
5 lung disease, can help perpetrate -- or perpetuate and
6 cause the decompression of an underlying lung disease
7 itself.

8 Q. What kinds of questions would you customarily
9 ask a patient such as Mr. Eastman the first time you met
10 him about his prior history of respiratory complaints,
11 if any?

12 A. You do ask about a smoking history when
13 someone present with respiratory problems. You ask a
14 history about childhood asthma, a history as far as
15 exposure to other potential processes that can
16 chronically affect the lungs, such as asbestos or
17 tuberculosis. Sometimes you'll ask about family history

18 of asthma, since asthma does run in families and family
19 members of asthmatics have a higher incidence of asthma
20 themselves.

21 Depending on the circumstances in the
22 radiographic picture, sometimes you ask about
23 occupational exposure of things other than asbestos.
24 That's usually when I have a stronger suspicion of
25 occupational lung disease. I did not ask Mr. Eastman

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1 anything about asbestos as far as occupational exposure.

2 Q. Did you ask him a question about his prior
3 symptoms, such as -- other than for the two-week period
4 before he presented to the hospital on June 10th, 1995,
5 did you ask Mr. Eastman whether or not he had a prior
6 history of shortness of breath or chronic productive
7 cough or things along those lines?

8 A. Frequently I will at some point. I can
9 probably assure you that in the emergency room at that
10 point in time I was probably focused in on the problem
11 he was there for and probably did not ask about previous
12 symptoms, at least at the time in the emergency room.

13 Q. If Mr. Eastman reported to you a positive
14 history of a productive cough or any kind of cough or
15 respiratory symptom that had been present over a
16 substantial period of time, is that something you would
17 document?

18 A. If I had asked him that question and it
19 appeared to be pertinent to his presentation, yes.

20 The one question I'm certain I did ask him was
21 had anybody -- did he have any known history of lung
22 disease prior to the admission, and he said no, he did
23 not have any known history?

24 But in saying that, just to a patient that
25 often means did a doctor ever tell you you had lung

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1 problems, and no one ever told him that.

2 I do not believe, in looking at the records, I
3 have not documented whether I questioned him about
4 symptoms, prolonged symptoms, chronic symptoms prior to
5 his presentation. I can virtually be certain in the
6 emergency room just in the nature of how you evaluate
7 patients in the emergency room, I probably did not get
8 into that detail of a history with -- of it with him at
9 that time.

10 Q. What significance would a prior history or the
11 lack of a prior history of those kinds of respiratory
12 complaints be to your development of a differential
13 diagnosis of Mr. Eastman's condition?

14 A. The presence of those types of symptoms would
15 make me more suspicious that he had chronic underlying
16 lung disease that was in current exacerbation, more so
17 than just an acute process in and of itself.

18 Q. Would the absence of a history like that be of
19 significance to you?

20 A. The absence of prior symptoms does not exclude
21 the absence of prior disease. So it would be worth
22 noting that he had no such symptoms, but does not
23 necessarily rule out any of the things that I would
24 place in my differential diagnosis.

25 Q. Would it increase your suspicion of the impact

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1 of the acute process being a contributor to the symptoms
2 that he presented with?

3 A. It would make me more suspicious that the
4 majority of the problems were related to the acute
5 illness.

6 Q. What questions would you have asked
7 Mr. Eastman with respect to his prior use of alcohol?

8 A. That is generally part of my routine questions
9 on the initial contact I've had with the patient.

10 Q. What would you ask?

11 A. Does he currently drink alcohol. If he
12 currently drinks alcohol, how much he drinks, how
13 frequently. And I do ask, you know, if he says he does
14 not drink alcohol, I will ask have you ever drunk
15 alcohol. Because that usually indicates either people
16 have a strong religious conviction or they have had
17 problems with it in the past if they are adamant about
18 complete abstinence.

19 Q. Would a history of significant daily use of
20 alcohol be relevant to your development of a treatment
21 plan?

22 A. For pneumonia, if it's a significant pattern
23 of alcohol abuse, that does lead to increased concerns
24 of aspiration, leading to pneumonia, as far as drinking
25 yourself to unconsciousness and possibly vomiting and

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1 aspirating stomach contents.

2 There's also a significant increased risk of
3 alcohol withdrawal and alcohol withdrawal seizures which
4 can cause -- lead to pneumonias. But the biggest
5 aspects of a -- when you're hospitalizing a patient who
6 has had a significant daily use of alcohol is you have
7 to watch for signs and symptoms of alcohol withdrawal as
8 a complicating factor of the hospitalization, no matter
9 what the reasons -- no matter what the reason they are
10 being admitted for.

11 Q. Dr. Tinsley, did you note Mr. Eastman's prior
12 history of testicular cancer?

13 A. Yes, I did.

14 Q. Did you develop a treatment plan for
15 Mr. Eastman after you assessed his condition on
16 June 10th, 1995?

17 A. Yes I did.

18 Q. And what was your treatment plan?

19 A. The initial treatment plan was to treat him
20 with intravenous antibiotics with the type of
21 antibiotics that would typically treat the majority of
22 the community-acquired pneumonias that you would see
23 walking in the emergency room, particularly in a smoker.

24 He did not appear to have bronchospasm, so we
25 were treating him with inhaled bronchodilators that

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1 would help both with the bronchospasm and with
2 mobilization of secretions. And -- are you talking
3 about just the first day I saw him?

4 (Whereupon, there was an interruption in the
5 reading of the deposition testimony, as follows:)

6 MR. ACOSTA: I think it said he did appear to
7 have some bronchospasm.

8 MR. DENSON: Oh, I'm sorry.

9 (Whereupon, the reading of the deposition
10 continued, as follows:)
11 A. He did appear to have bronchospasm, so we were
12 treating him with inhaled bronchodilators that would
13 help him both with the bronchospasm and the mobilization
14 of secretions. And -- are you talking about just the
15 first day I saw him?
16 Q. Yeah, what was the treatment plan that you
17 identified on the first day?
18 A. The first day was antibiotics, Albuterol and
19 hydration. But although not stated, the plan was to
20 further assess him for signs of chronic lung disease,
21 depending on his response to therapy.
22 Q. Did you have a discussion with him about his
23 tobacco use on the first day that you saw him?
24 A. I cannot swear I talked to him about it the
25 first day I saw him, no.

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1 Q. I'm looking at page 25 in the chart, and I see
2 a reference under activities to he was told to avoid
3 tobacco use at all costs. Do you see that?
4 A. Page 25?
5 Q. Yes.
6 A. Yes.
7 Q. Do you see anywhere else in the chart in your
8 progress notes, for example, that identifies anything
9 else about the conversation that you had with
10 Mr. Eastman about tobacco?
11 A. There's nothing documented in the progress
12 notes when I may have had that conversation with him.
13 Q. I don't want to be redundant, but is there
14 anything in looking at the chart that you would have
15 told him in particular with respect to advice on smoking
16 and health and cessation?
17 A. It's not documented in the chart, but I can
18 assure you that within the first 48 hours of his
19 admission that I would have discussed with him the
20 amount of tobacco he was smoking, that it was adversely
21 affecting his health, and it may have contributed to
22 even catching the pneumonia. And then he would be
23 advised to reduce and discontinue did it.
24 Prior to his discharge we did do pulmonary
25 function testing and -- that did document he did have

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1 obstructive lung disease, which is correlated highly
2 with the use of tobacco smoke?
3 And I can tell you certainly --
4 (Whereupon, there was an interruption in the
5 reading of the deposition testimony, as follows:)
6 MR. DENSON: Excuse me.
7 (Whereupon, the reading of the deposition
8 continued, as follows:)
9 A. And I certainly -- and I can certainly tell
10 you after seeing a pulmonary function tests I would have
11 more vigorously, and I'm certain I did more vigorously
12 instruct him that the smoking had already impacted upon
13 his health and that discontinuing his tobacco use was
14 imperative for his health and well-being given the
15 impact it had already had on his pulmonary function.
16 Q. How would you characterize the results of the
17 pulmonary function tests in simple terms that the jury

18 can understand?

19 A. We would call it a severe obstructive
20 ventilatory defect, which means that he has an
21 obstruction to air flow on exhalation.

22 It falls in the severe category to make it a
23 point that his functional capacity at the time he was
24 being tested showed his ability to expel air from his
25 lungs were only one -- approximately one-third of what

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1 would be predicted for a man his age and his weight,
2 that these findings are consistent with chronic
3 obstructive pulmonary disease, which is the most common
4 form of lung disease associated with smoking cigarettes.

5 Q. And directing your attention to page 34 in the
6 chart, I see it looks like, I think that's an order at
7 the bottom of the page related to respiratory therapy
8 instructions?

9 A. Yes.

10 Q. What does that refer to?

11 A. You're you talking about the first one under
12 6/20/95? DC home, discharge home.

13 Q. I'm looking at the second one with respect to
14 the part that talks about respiratory therapy
15 instructions.

16 A. Oh. Change his nebulizer, which is a passive
17 method of administration of medication, over to an MDI,
18 a metered-dose inhaler, where it's just
19 self-administered by the patient, whereas the nebulizer
20 treatment you just put in your mouth and breathe deeply.
21 The metered does inhaler takes some coordination and
22 specific breathing instructions to take it
23 appropriately?

24 So I was asking respiratory therapy -- I was
25 changing him from the nebulizer to that metered-dose

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1 inhaler, to come in and instruct him on the appropriate
2 techniques so that he could get maximum medical benefit.

3 Q. And the documentation here just confirms that
4 that's been done with Mr. Eastman?

5 A. I have to find the respiratory therapy notes.
6 I don't see documentation by them that they gave him the
7 instructions.

8 Q. Which form are you looking at there?

9 A. I'm looking at, like, 74, 75 and 76. These
10 are the nursing forms. At some point I know that --

11 Q. Looking at page 76, let's take a look at that.

12 A. Okay.

13 Q. Up at the top with respect to educational
14 assessment, what box is checked?

15 A. Okay. This is the generic teaching plan per
16 the nurses. Now, are you talking about page 76?

17 Q. Right.

18 A. They say the patients was eager to learn, his
19 knowledge appeared adequate, there's no barrier to
20 learning, and there was no cultural or religious beliefs
21 that would affect the education plan.

22 Q. While we have the nursing assessment out, can
23 you take a look at page 71 there as well. And in
24 section G, what does that reflect there with respect to
25 Mr. Eastman's tobacco habit?

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1 A. He said he was -- he said he was currently
2 smoking and he states that he's going to quit his
3 tobacco use.

4 Q. What does it state there with respect to his
5 use of alcohol?

6 A. Beer only.

7 Q. In a patient such as Mr. Eastman, when giving
8 him advice at the time of discharge regarding his
9 lifestyle in addition to suggesting that he quit
10 smoking, did you make any suggestions with regard to his
11 use of alcohol?

12 A. I did not. I would if a patient seemed to be
13 drinking an excessive amount or it -- or may be
14 impacting adversely on his health.

15 Q. And how would you make that determination?

16 A. First off, if he has any disease process
17 that's affected by alcohol use, and also it depends on
18 the quantity and frequency of drinking.

19 Q. Did you have a habit in practice of
20 instructing the patients under your care with respect to
21 the importance of the use of their inhalers?

22 A. Yes.

23 Q. Can you, and again, in lay terms, describe
24 what your custom, habit and practice was at the time
25 that you treated Mr. Eastman when instructing him

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1 regarding the use of inhalers.

2 (Whereupon, there was an interruption in the
3 reading of the deposition testimony, as follows:)

4 MR. ACOSTA: Oh, it was them. I'm sorry.

5 (Whereupon, the reading of the deposition
6 continued, as follows:)

7 A. If not in the hospital, if I'm initiating
8 therapy in my office, I go over the appropriate
9 techniques of using the inhaler. If you're using the
10 inhaler for chronic obstructive pulmonary disease and
11 not asthma, it also depends upon the severity of the
12 disease, but that continuing use and daily use and the
13 appropriate frequency of use can help maintain a patient
14 in their best functional status with minimizing of
15 symptoms to the best degree, depending on the patient's
16 underlying disease status.

17 At the lesser diseases, at the milder
18 diseases, at times you can instruct the patient that
19 they can use it just as needed. But on the more severe
20 diseases, the habit of using it as instructed can lead
21 to maintenance of a better quality of life and actually
22 may decrease the frequency of recurrent infections and
23 exacerbation by maintaining their airways and keeping
24 their lungs in optimal status.

25 Q. So in a patient such as Mr. Eastman, who you

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1 determined had a severe COPD, what would you have said
2 to him?

3 A. I told him that medical appliances is impaired
4 it, to take the medicines as instructed at the routine
5 that we instructed them. I would tell him to cease
6 smoking. I would tell him that he needs a yearly flu
7 vaccine as a preventative measure and that probably a
8 pneumococcal vaccine would be of benefit, and that

9 seeking of early medical intervention at the earliest
10 signs of infection would help prevent the need for
11 hospitalization and make us able to treat an
12 exacerbation before it became severe enough to require
13 hospitalization.

14 Q. If a patient requested your assistance in
15 quitting smoking, is that something you would have a
16 habit of documenting?

17 A. If he had requested assistance in
18 discontinuation of tobacco, yes.

19 Q. And did you see anything where you determined
20 that Mr. Eastman asked for your assistance in quitting
21 smoking.

22 (Whereupon, there was an interruption in the
23 reading of the deposition testimony, as follows:)

24 MS. FAGGIANELLI: It should be documented.

25 MR. ACOSTA: Well, there's two questions here.

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1 Let me just read the second question --

2 MR. DENSON: Okay.

3 MR. ACOSTA: -- since there's no answer to the
4 first question.

5 (Whereupon, the reading of the deposition
6 continued, as follows:)

7 Q. As you're looking at your chart, I guess what
8 would you put in your chart? What would you write down?

9 A. Well, if the patient had asked to discontinue
10 his tobacco use, I would ask -- I would probably -- I
11 would state that the patient is having difficulty
12 stopping on his own and I would document the medications
13 or referrals that I made in regard to that.

14 Q. And that sort of documentation's part of your
15 custom, habit and routine during the time period that
16 you were treating Mr. Eastman?

17 A. Yes.

18 Q. And feel free to look at the medical record or
19 the office chart you have there, but do you see any
20 indication in the medical record or your hospital chart
21 that you wrote down what you've just described you would
22 typically write down if a patient asks for your
23 assistance in quitting?

24 A. I don't see any documentation that anything
25 was prescribed specifically to assist him in his

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1 discontinuation of tobacco use. He was prescribed
2 Zoloft, but according to the records, his wife had
3 reported to me that she felt he was suffering from
4 depression and I chose Zoloft because sometimes the
5 antianxiety --

6 (Whereupon, there was an interruption in the
7 reading of the deposition testimony, as follows:)

8 MR. DENSON: Excuse me.

9 (Whereupon, the reading of the deposition
10 continued, as follows:)

11 A. And I chose Zoloft because sometimes the
12 antianxiety properties of that can help ease the
13 nicotine craving or the anxiety that occurs when people
14 are often going through nicotine withdrawal, is the
15 reason I chose that particular one. But the reason for
16 administration was not at the patient request, but at
17 the wife's request that she felt he was having

18 depression.
19 Q. If a patient was experiencing anxiety or
20 withdrawal symptoms, is that something you would make a
21 practice to document as part of your clinical
22 documentation?
23 A. Yes.
24 Q. And as of the prescription for Zoloft that you
25 see in the chart made at the request of Mr. Eastman's
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1 wife, do you see any documentation by you of clinical
2 signs or symptoms of withdrawal?
3 A. There's nothing documented in the hospital
4 records.
5 Q. Did you see Mr. Eastman again after he was
6 discharged from the hospital?
7 A. Yes.
8 Q. And on -- what was the first date that you saw
9 Mr. Eastman?
10 A. July 6th of 1995.
11 Q. Did you make any record in your office chart
12 here that identified a particular clinical problem that
13 Mr. Eastman expressed to you as being related to a
14 difficulty in quitting smoking?
15 A. He did not report to me any difficulty in
16 discontinuing his tobacco use.
17 Q. Having seen Mr. Eastman on two occasions in
18 July of '95 and August of '95, would it have been your
19 custom, habit and practice to discuss with him the
20 importance of the use of his inhaler regimen?
21 A. Yes. I would have instructed him to continue
22 to be compliant with his inhaler regimen.
23 Q. If Mr. Eastman had reported to you that he had
24 some difficulty understanding how to use them or why to
25 use them, and would that be something that you would
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1 document in your chart?
2 A. Yes.
3 Q. Do you see any sign of that documentation in
4 your chart?
5 A. I did not see him expressing any questions
6 about the use of the inhalers. My nurse does document
7 that he was using the inhalers less than the prescribed
8 amount.
9 Q. Upon seeing that documentation, would you have
10 a conversation with the patient about the importance of
11 complying?
12 A. Yes.
13 Q. What would you say?
14 A. I would say that he needs to take the
15 medication as prescribed. It would be to his benefits
16 and help prevent exacerbations of his underlying lung
17 disease.
18 Q. Did you -- did you ask Mr. Eastman to return
19 to you for further care and treatment?
20 A. Yes.
21 Q. When did you ask him to return?
22 A. In one month.
23 Q. Did Mr. Eastman ever return to you?
24 A. No, he did not.
25 Q. I'm going to tender to you a document entitled
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1 Clinics in Chest Medicine and ask that you identify it
2 for the record.

3 A. It's Clinics and Chest Medicine, Smoking and
4 Pulmonary Vascular Diseases, Volume 21, Number 1,
5 March 2000.

6 Q. Does the section of pulmonary and critical
7 care associated with the university -- the Yale
8 University School of Medicine enjoy a good reputation in
9 the medical community?

10 A. Yes.

11 Q. With what -- with respect to the topic of
12 smoking and chronic obstructive pulmonary disease, would
13 this be a reference source such that pulmonologists,
14 internists, and critical care specialists would refer to
15 when they were looking for information on smoking and
16 chronic obstructive pulmonary disease?

17 A. Yes.

18 Q. And it would be reasonable to do that?

19 A. Yes.

20 Q. There would be no basis, looking at what you
21 see identified here, to exclude this from the reasonable
22 sources of medical information about smoking and chronic
23 obstructive pulmonary disease, would there?

24 A. No reason to exclude?

25 Q. Yeah, no reason to exclude this from your

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1 review?

2 A. No, I would not exclude this from my review.

3 Q. One question about this. Turn to page 69 to
4 70. And it goes to the bottom right-hand column to the
5 top of the next page. Can you read the sentence that
6 begins at the bottom right-hand column?

7 A. Intriguingly, three studies have implicated
8 alcoholic consumption as a risk factor for COPD.

9 Q. Can you continue to the next?

10 A. One study found former alcohols to have a
11 higher prevalence of air flow obstruction. And in the
12 Tucson study alcohol proved to be a significant
13 predictor of lung function after controlling for
14 smoking.

15 Q. In your own personal experience, have you
16 treated patients with COPD and who have a history of
17 excessive alcohol consumption?

18 A. Yes.

19 Q. Do you advise them as a matter of routine
20 habit, custom to stop drinking alcohol as well if they
21 are continuing to drink alcohol in an excessive amount
22 while they have COPD?

23 A. If people appear to be drinking alcohol in an
24 excessive amount that is compromising their health, yes,
25 I advice them to discontinue their tobacco use -- their

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1 alcohol use.

2 Q. First I would like to ask you, we're here in
3 your office in Clearwater; is that right?

4 A. That's correct.

5 Q. And what hospitals in the local area here are
6 you on staff or which hospitals do you have privileges
7 to practice?

8 A. Morton Plant Hospital, Largo Medical Center,

9 Suncoast Hospital, and HealthSouth Rehabilitation
10 Center.
11 Q. And do you see patients on a daily basis?
12 A. Yes.
13 Q. And do you have rounds that you make at the
14 hospitals?
15 A. Yes.
16 Q. And as I understand it, about 45 percent of
17 your patients are lung patients that deal with lung
18 diseases --
19 A. Yes.
20 Q. -- of one kind or another?
21 A. Yes.
22 Q. And that would include lung cancer?
23 A. Yes.
24 Q. And emphysema?
25 A. Yes.

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1 Q. And chronic bronchitis?
2 A. Yes.
3 Q. Asthma and lots of other kinds of diseases?
4 A. Yes.
5 Q. And you've indicated that you plan to
6 recertify yourself in that subspecialty of internal
7 medicine within the next year?
8 A. Recertify in the specialty of pulmonary
9 medicine, yes.
10 Q. In terms of emphysema, can you tell us what
11 kind of a disease that is?
12 A. It's considered a disease of obstruction to
13 air flow. Nowadays we combine the diagnoses of
14 emphysema with chronic bronchitis under a unified term
15 COPD, chronic obstructive pulmonary disease, because no
16 one has truly just emphysema or just chronic bronchitis.
17 Everybody has a mixed pattern?
18 But specifically emphysema involves the
19 destruction of the air exchange units such that you have
20 large cavitory lesions within the lung where there's
21 absence of functional lung tissue which leads to the
22 potentially low oxygen units, but more specifically
23 because of decreased tethering of the airways opened by
24 the elasticity of the lung which is lost with the
25 destruction of the tissue, the airways tend to close

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1 prematurely on exhalation.
2 Q. Can you describe what air trapping is?
3 A. Air trapping is when you have what we consider
4 an elevated residual volume, which is the amount of air
5 that's left in the lung after a forced expiration such
6 that a person cannot expel the total amount of air that
7 he normally would be able to do in someone usually of
8 his age, weight, and sex, that this decrease in the
9 ability to expel the normal amount of air leads to an
10 elevated amount that is left in the lung after a
11 complete forced exhalation.
12 Q. When a person who has a chronic obstructive
13 pulmonary disease inhales material, you know, in the
14 form of smoke or dust or anything like that, are they
15 more likely to stay to stay in the lung?
16 A. It depends on the chronic and the continuous
17 nature of the exposure. Inhaled materials tend to stay

18 in the lung longer than someone with normal lungs.
19 Q. What is the reason for that?
20 A. Well, it depends on the degree of inhalation.
21 Again, if you have the phenomenon which we call air
22 trapping and premature closure of the airways such that
23 you do not necessarily have a complete emptying of all
24 the air pockets within the lung with every exhalation,
25 that there is a, basically what we call air trapping.

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1 Because of -- because of some of those
2 premature, you don't always -- it takes longer to
3 equilibrate the inhaled materials with the external air
4 and, therefore, they are left in there longer than
5 someone without the disease process.
6 Q. Aside from the air trapping, is there a
7 mechanism within the lungs that helps the lung to clean
8 itself?
9 A. Well, there's the mucous production itself, so
10 that the -- if there's a particulate matter, the mucous
11 will entrap some of this particulate matter, which would
12 also hold it in the air longer.
13 (Whereupon, there was an interruption in the
14 reading of the deposition testimony, as follows:)
15 MR. DENSON: Excuse me.
16 (Whereupon, the reading of the deposition
17 continued, as follows:)
18 A. Then there's what we call the cilia within the
19 lung which move trapped material out which is typically
20 impaired in people with these disease processes.
21 Q. What is the -- what does the cilia look like?
22 A. They are frequently described on microscopic
23 analysis as either little hairlike or fingerlike
24 projections that move in a considered manner to move
25 things out of the lung to the upper airways for

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1 expectoration.
2 Q. Or swallowing?
3 A. Or swallowing, yes.
4 Q. And does cigarette smoke have an effect on the
5 cilia and the mucous flow in the lung?
6 A. It increases mucous flow as far as mucous
7 production, but decreases the ability to clear this
8 mucous. The cilia, the initial stages are paralyzed
9 with the initial exposure to tobacco. With chronic
10 exposure the cilia become blunted and even lost and
11 denuded.
12 Q. What effect does the paralysis of the cilia
13 and the increased mucous flow have on the ability of the
14 lung to clean itself?
15 A. Well, without the ability to clear the
16 secretions, the secretions stay in the lungs longer.
17 And the secretions themselves are proteins and sugars
18 which are a media for bacterial growth.
19 Q. On the subject of cigarette smoking, you
20 indicated that you generally advise your patients that
21 they should not smoke; is that fair?
22 A. Yes.
23 Q. And, of course, patients that come to you with
24 lung diseases that smoke you are more emphatic with?
25 A. Correct.

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1 Q. What percentage of your patients have chronic
2 obstructive pulmonary disease, either chronic bronchitis
3 or emphysema or a mixture of the two and are cigarette
4 smokers?

5 A. You mean currently or have been?

6 Q. Say in the last ten to 13 years, since 1990.

7 A. I mean, that's what I'm asking you. Are you
8 asking me were they -- have they ever smoked cigarettes
9 or do they still smoke at the current time of the
10 disease?

11 Q. Current or former. Both.

12 A. I would say people with COPD, I would say at
13 least -- it would be greater than 90 percent, probably
14 in the range of 95 percent are smokers or previous
15 smokers.

16 Q. My question is limited simply to when a person
17 comes to you for the first time and is diagnosed with
18 COPD. How many of those people are current smokers or
19 smokers at the time you make the diagnosis?

20 A. Probably about 50 percent or maybe a little
21 bit more.

22 Q. And you indicated, I believe, when you were
23 questioned earlier that you tried to get them to I
24 didn't tell smoking if possible. And my question is
25 what did you mean by, quote, if possible, end quote?

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1 A. Not every patient who wants to discontinue
2 smoking, and even the patients who want to discontinue
3 smoking, not every patient is able to discontinue
4 tobacco use.

5 Q. Those that want to quit smoking that are
6 unable, is there a physiological -- a physiologic basis
7 for their inability to quit smoking, to your knowledge?

8 A. There is proposed both physiologic and
9 behavior problems with their continued --
10 discontinuation of smoking.

11 Q. When you say proposed, what do you mean by
12 that?

13 A. I don't know that one study has shown a
14 specific enzyme pathway or physiologic change that makes
15 the patient dependent on nicotine or tobacco smoke.

16 There are a lot of studies looking at
17 behavioral aspects of people smoking and physiologic
18 changes in people going through nicotine withdrawal that
19 propose that there is in some people, not all people, an
20 addictive reaction to nicotine or to other aspects of
21 tobacco smoke that do make certain patients addicted to
22 the tobacco smoke.

23 Q. Is nicotine dependence or addiction to
24 cigarettes something that influences the behavior of the
25 smoker?

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1 A. Yes.

2 Q. In what manner does it influence the behavior
3 of the smoker, based upon your knowledge and background
4 and care?

5 A. Again, even when a patient is aware the
6 smoking is having an adverse health consequences, that
7 they continue to smoke. In their efforts to discontinue
8 smoke, they oftentimes become agitated, moody,

9 depressed.

10 Q. When do those symptoms of agitation or
11 moodiness or depression, when do you -- when do those
12 usually occur after a person has had his last cigarette?

13 A. It depends on how frequently and how much that
14 person smoked.

15 Q. Let's assume that it's, you know, a one to
16 two-pack-a-day smoker. How soon after the last
17 cigarette would they experience withdrawal symptoms, as
18 you describe them?

19 A. It could be within 30 minutes to an hour, hour
20 and a half. It's been shown that patients who smoke
21 cigarettes smoke to attain a certain nicotine level in
22 their blood. Now, when that level drops below their
23 preset level, they do start experiencing the cravings
24 and signs and symptoms of nicotine withdrawal.

25 Q. And then how long usually do the withdrawal

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1 symptoms last?

2 A. Variable. I've had some patients say that
3 they continue to crave and want cigarettes for years
4 after their last cigarette. You do not have the -- you
5 do have the occasional patient who obviously did not
6 have a nicotine addiction despite a significant smoking
7 history who said, I put the pack of cigarettes down and
8 never looked back.

9 But the acute rise in heart rate, rise of
10 blood pressure, tremulousness sometimes can last, the
11 physiologic changes can last for weeks and weeks after
12 the last cigarette. The craving, though, can last for
13 years.

14 Q. All right. In terms of the acute withdrawal
15 symptoms such as irritability, anxiety, jitteriness or
16 nervousness, how long do those usually last?

17 A. Usually days to week.

18 Q. Now, in Mr. Eastman's case, he was
19 hospitalized on June 10th. Do you know when he had his
20 last cigarette?

21 A. When he was admitted, he had told me he had
22 been continuing to smoke, but I don't know when his last
23 cigarette was as far as in relationship to his
24 admission. I can't tell you if it was that day or days
25 before that he had had his last cigarette.

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1 Q. Now, when he was in the hospital, was he
2 admitted immediately from the emergency room?

3 A. Yes, he was.

4 Q. And what was the reason he was admitted
5 immediately from the emergency room?

6 A. Because he had evidence of pneumonia and he
7 had low oxygen levels.

8 Q. And you used the term hypoxic previously?

9 A. Yes.

10 Q. In lay terms, what does that mean?

11 A. Low oxygen levels.

12 Q. And what effect does that have on a person to
13 have a low oxygen level like his?

14 A. It depends on the degree of the low oxygen
15 level. The first arterial blood glass we had was on
16 four liters per minute, which had corrected that?

17 But hypoxic levels of 85 to 90 percent

18 saturation of oxygen has little effects. Oxygen levels
19 below that, 80, 85 percent, people oftentimes will feel
20 short of breath. And in chronic long-term, you start
21 finding the chronic long side effects of hypoxia.
22 It depends on the rapidity of onset of the
23 symptoms. There are some patients who have had a
24 chronic low level of oxygen that has been gradually
25 progressive who have low oxygen levels that would make a

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1 person unconscious if it happened acutely, but because
2 their body has had time to compensate for it, they can
3 walk into the emergency room and look normal yet have an
4 oxygen level that sometimes we feel is incompatible with
5 consciousness.

6 But if you start getting saturations
7 particularly below 80, 75 percent, you can start seeing
8 agitations -- agitation, sometimes lethargy, again
9 disorientation, confusion, weakness, difficulty
10 ambulating. So acutely low oxygen levels can be quite
11 significant and lead to unconsciousness even.

12 Q. At what level was Mr. Eastman's when --

13 A. I don't know what level it was because he
14 first -- because the first arterial blood gas that we
15 did, we had him on four liters per -- four liters per
16 minute oxygen.

17 Typically inspired oxygen is 21 percent. Four
18 liters would be approximately anywhere from 36 to
19 40 percent oxygen, so almost double the amount of oxygen
20 that you or I would have. And it raised his oxygen
21 level to a normal level, but I don't know what it was
22 when he walked in the door. I just don't have that
23 information.

24 Q. Was he put in a room and put in bed
25 essentially?

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1 A. Yes.

2 Q. And I believe you said he was given
3 intravenous IVs, which were both to hydrate him and to
4 give him -- to hydrate him to give him body fluids?

5 A. Correct.

6 Q. And another for antibiotics?

7 A. Correct.

8 Q. And was he also given other medications while
9 he was in the hospital?

10 A. He was eventually started on intravenous
11 steroids. He was started on aminophylline.

12 Q. And what does aminophylline do?

13 A. It works as a bronchodilator. It has several
14 physiologic effects that can be useful in the treatment
15 of someone with chronic obstructive pulmonary disease.

16 Q. And any other medications that he was put on?

17 A. Just, again, the Zolof that we mentioned
18 earlier, the aminophylline products, the antibiotics,
19 and the inhaled bronchodilators.

20 Q. Now, when John Eastman was in the hospital he
21 had -- did he wear an oxygen mask?

22 A. We gave him what we call nasal cannula oxygen,
23 which is the prongs in the nose which supply the oxygen.

24 Q. Was Mr. Eastman permitted to smoke in the
25 hospital?

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1 A. If a patient is alert and oriented, we cannot
2 restrict a patient from smoking. They are not allowed
3 to smoke in the hospital, but there is a smoking area
4 outside the hospital.

5 Q. Well, let me ask you. Did he have a portable
6 oxygen system in the hospital, or was it some other
7 system?

8 A. To my knowledge in the hospital he only had
9 the wall attachment.

10 Q. And was he on oxygen 24 hours?

11 A. Twenty-four hours a day while in the hospital
12 except maybe just for very brief periods of coming off.

13 Q. And was he permitted to leave his room?

14 A. Again, we can't restrict a patient who's alert
15 and oriented from doing things. So he could have walked
16 out of the room. We discouraged it. We discourage them
17 from leaving the floors. To my knowledge, he didn't
18 leave the floor.

19 Q. To your knowledge, was he in and out of bed
20 during that time?

21 A. We try not to restrict the --

22 (Whereupon, there was an interruption in the
23 reading of the deposition testimony, as follows:)

24 MR. DENSON: Excuse me.

25 (Whereupon, the reading of the deposition

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1 continued, as follows:)

2 A. We try not to restrict the patient to bedrest.
3 We want them to be up and moving around.

4 Q. When he left the hospital, he was on portable
5 oxygen at that time?

6 A. He would have a home-based unit and did have a
7 portable -- and did have portable oxygen at home, yes.

8 Q. And how long -- how long was he on that before
9 you said he could go off the oxygen?

10 A. He was discharged on the 20th, and he was
11 given instruction on July 11th that he could discontinue
12 the oxygen. So that would be about three weeks.

13 Q. And was he on other medications upon
14 discharge?

15 A. He remained on TheoDur, Zolof. He was weaned
16 down and off the prednisone. He was on the inhaled
17 bronchodilators along with a sleeping pill, which was
18 ProSom.

19 Q. And what was the purpose of the
20 bronchodilators?

21 A. Again, to decrease the spasm of the airways,
22 to open the airways up and ease the air flow of the
23 lungs.

24 Q. Was it to help him breathe?

25 A. Yeah.

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1 Q. Did pneumonia resolve itself?

2 A. Yes.

3 Q. Now, you indicated that for patients that you
4 have advised to quit smoking that you would discuss with
5 them strategies if either they asked for it or you
6 wanted -- under what circumstances would you give them
7 strategies?

8 A. If a patient stated they had the desire to

9 stop smoking but were unable to do so, I would discuss
10 various strategies that were available to a patient.
11 Q. Okay. And what -- why are strategies needed?
12 A. Because the -- for tobacco smoking, there's
13 both a behavioral aspect and a psychologic aspect of the
14 desire --
15 (Whereupon, there was an interruption in the
16 reading of the deposition testimony, as follows:)
17 MR. ACOSTA: It's physiological.
18 MR. DENSON: Oh, excuse me, physiologic.
19 (Whereupon, the reading of the deposition
20 continued, as follows:)
21 A. There's a behavioral aspect and a physiologic
22 aspect of the desire to keep smoking. So you have to
23 tailor something to both deal with what we consider the
24 chemical addiction and also the behavioral problems.
25 Q. If Mr. Eastman was on Zoloft for whatever
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1 reason while he was in the hospital, would that reduce
2 the anxiety that may accompany withdrawal from
3 cigarettes?
4 A. Zoloft was given both for anxiety and
5 depression. The hope was that the Zoloft would reduce
6 any anxiety resulting from the nicotine withdrawal,
7 although I don't know of any study that shows Zoloft is
8 useful as far as an aide in discontinuation of tobacco
9 use.
10 We do frequently use many antianxiety
11 medicines that haven't been definitely shown to help
12 people stop smoking either.
13 Q. Is there generally a dose response to nicotine
14 in cigarettes?
15 A. There's a dose response to the health issues
16 involved as far as the degree of tobacco use and
17 longevity of tobacco use, there's a definite dose
18 response relationship.
19 Again, people do -- it's been shown on
20 numerous occasions that people smoke to maintain a level
21 of nicotine in their bloodstream, and for those people,
22 yes, there seems to be a dose response. If they smoke
23 less than the amount to achieve that nicotine level,
24 they have a physiologic response.
25 Q. And are there nicotinic receptors in the
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1 central nervous symptoms?
2 A. Yes.
3 Q. What are they?
4 A. There are various neuro transmitters used in
5 different pathways in the brain. Again, certain ones
6 which we call nicotinic we know definitely respond to
7 the effect of nicotine. There's other forms we call
8 muscar- --
9 (Whereupon, there was an interruption in the
10 reading of the deposition testimony, as follows:)
11 MR. ACOSTA: Muscarinic.
12 (Whereupon, the reading of the deposition
13 continued, as follows:)
14 Q. -- (continuing) muscarinic that again respond
15 to different type of chemical structures.
16 Again, we do have pathways called the
17 nicotinic pathways in the brain, although I can't really

18 tell you exactly what these pathways are involved as far
19 as the physiologic -- physiology that they control.
20 MR. ACOSTA: Your Honor, might this be a good
21 time for us to --
22 THE COURT: Okay. I was hoping that it was.
23 All right. We'll take a 15-minute afternoon
24 recess.
25 THE BAILIFF: All rise. Court's in recess for
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1 15 minutes.
2 (Whereupon, a brief recess was taken, after
3 which the following proceedings transpired:)
4 THE COURT: Mr. Acosta.
5 MR. ACOSTA: Yes, sir.
6 THE COURT: How much longer?
7 MR. ACOSTA: I'm guessing about 20 minutes on
8 this one.
9 THE COURT: On yours?
10 MR. ACOSTA: Of the whole thing. I read
11 theirs after all because it was bad enough the way
12 it was, but it would have been even worse. I made
13 the decision to do it. I told her I was going to
14 do it. She did have an objection she wanted to
15 raise.
16 THE COURT: I just told the sheriff to bring
17 the jury in.
18 MR. DENSON: It's for the next one.
19 MR. ACOSTA: The next one we are going to try
20 to do the sound, so... The next one is about 45
21 minutes, so that will take us pretty close to --
22 depending on how much they want to read. That one
23 is my cross on video, so there won't be anything to
24 add to that.
25 THE COURT: All right. Let's proceed.
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1 MR. ACOSTA: May it please the Court. Page
2 111.
3 (Whereupon, the continuation of the deposition
4 testimony of Steven B. Tinsley, M.D. was read to the jury,
5 with Mr. Acosta reading the questions and Mr. Denson
6 reading the answers, as follows.)
7 BY MR. ACOSTA:
8 Q. I believe you said that he had an early right
9 lower lobe infiltrate.
10 A. Right.
11 Q. What does that mean?
12 A. It's a radiographic evidence, an x-ray
13 evidence of changes in the lung that would suggest
14 infection.
15 Q. I believe you said he had rales in the right
16 base. That would mean that you listened to both sides
17 of his chest but he only had them on one side?
18 A. Correct.
19 Q. And are rales a sound that's heard when you
20 put a stethoscope on the chest?
21 A. Yes, it is.
22 Q. And is it a sound that's specific to the
23 opening and closing of the airways? I mean, the air
24 sacks. I'm sorry.
25 A. That's the general belief, but it has to do
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1 with the opening and closing of the alveoli.
2 Q. Well, let me ask it. Just based on your
3 assessment, did he have wet or dry rales?
4 A. I would say wet.
5 Q. And would wet rales be consistent with the
6 infiltrate of fluid in his lung?
7 A. It would be more suggestive of that, yes.
8 Q. Are those things what primarily led you to
9 diagnose a pneumonia?
10 A. Yes.
11 Q. Now, are smokers more likely to get pneumonia
12 than nonsmokers?
13 A. Yes.
14 Q. Why is that?
15 A. Because the contents of tobacco smoke actually
16 inhibits the inflammatory process.
17 (Whereupon, there was an interruption in the
18 reading the deposition testimony, as follows:)
19 MR. ACOSTA: No. Response.
20 MR. DENSON: Excuse me.
21 (Whereupon, the reading of the deposition
22 continued, as follows:)
23 A. Because the contents of tobacco smoke actually
24 inhibits the inflammatory response and inhibits the
25 immune response to infection. It has been shown to
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1 paralyze the macrophages and the polymorphonuclear
2 leukocytes, the white cells that are involved in
3 combating infection. Also, it helps -- it does decrease
4 the lung's defenses against infection as we talked about
5 inhibiting the ability to clear secretions, paralyzing
6 the cilia within the lung, or making the cilia
7 dysfunctional as part of the airway defenses. So it
8 inhibits the airway defenses, the lung's defenses
9 against infection.
10 Q. Now, you were asked some questions about
11 alcohol. And if a person who's an alcoholic or has
12 difficulty with his consumption of alcohol and is
13 hospitalized for pneumonia or for anything else, is the
14 alcoholism something that's taken into account when the
15 patient is in the hospital?
16 A. Yes.
17 Q. And why is that?
18 A. Well, again, when a patient is hospitalized,
19 we don't supply them alcohol. So if they are alcohol
20 dependent, then there's the chance they may go through
21 alcohol withdrawal within the hospital, which we like to
22 be aware so we can treat it appropriately and hopefully
23 prevent some of the complications of alcohol withdrawal.
24 Also, people who are alcoholics tend to be
25 malnourished, then to be noncompliant with medical
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1 therapy, so -- and also alcohol itself has adverse
2 health issues which may or may not be related to the
3 reason the patient is in the hospital.
4 Q. Did Mr. Eastman present with any signs of
5 alcohol abuse?
6 A. No.
7 Q. And of course he didn't have any symptoms of
8 alcohol abuse, did he?

9 A. Not to my knowledge, no.
10 Q. And the history that was given regarding his
11 consumption of alcoholic beverages was what?
12 A. He drank beer occasionally.
13 Q. Did you think that Mr. Eastman's lung
14 condition could have --
15 (Whereupon, there was an interruption in the
16 reading the deposition testimony, as follows:)
17 MR. ACOSTA: Excuse me. I need to strike
18 that. We're going to have to skip to 118, line --
19 I want to just leave it in.
20 (Whereupon, the reading the deposition testimony
21 continues, as follows:)
22 Q. Did you think that Mr. Eastman's lung
23 condition could have been related to radiation exposure?
24 A. The spirometry that was performed was
25 inconsistent with damage from radiation exposure.

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1 Q. And was it consistent with something else
2 then?
3 A. It was consistent with obstructive lung
4 disease, the COPD.
5 Q. Let me ask you, do you have an opinion within
6 a reasonable degree of medical probability as to whether
7 or not Mr. Eastman's smoking history was causative in
8 his COPD?
9 A. The tobacco use would be the number one
10 instigating factor in his lung disease.
11 Q. Why is it that people can have moderate to
12 severe COPD, either emphysema, chronic bronchitis or
13 both, and not have any symptoms until it reaches a
14 certain point?
15 A. Because as with many organs in the body,
16 there's a definite reserve capacity that's available to
17 a person. Again, it depends on how much of that reserve
18 they use. As an analogy I use, where they are a
19 professional sprinter, obviously they need more reserve
20 than someone who sits at a computer terminal.
21 Therefore, people who use less of their reserve will not
22 notice any symptoms until all of their reserve is gone
23 and now it's impeding on their functional amount,
24 functional lung capacity they use in their everyday
25 life.

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1 Q. Page 60. Let's look at this. Look at page 60
2 zero of your records there and tell me what
3 Mr. Eastman's predicted forced vital capacity was?
4 A. 4.5 liters is the total amount of air he
5 should be able to expire with the maximal inspiration,
6 and to maximally expire would be 4.5 liters. The FEV1
7 would be three and a half liters as far as his predicted
8 value.
9 Q. Approximately how much of what he should have
10 been able to expire was he able to expire?
11 A. In one second he was only able to expire
12 35 percent of what he should -- of what should have.
13 In one second he was only able to expire
14 35 percent of what would have been predicted for him.
15 Q. So that's about one-third?
16 A. About one-third, yes.
17 Q. Now, you mentioned emphysema a minute ago. Is

18 the destruction -- and you mentioned the destruction.
19 The tissue is destroyed in that process?
20 A. Yes, it is.
21 Q. Is it curable?
22 A. By medical science, no. At its current
23 stages, no.
24 Q. And you were asked some questions regarding
25 his use of medications at the time he got out of the
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1 hospital. Do you recall that?
2 A. Yes.
3 Q. You mentioned something called a nebulizer.
4 What is a nebulizer?
5 A. A nebulizer is what he was using in the
6 hospital. That's when you put the medicine directly in
7 a container that has forced air through it that all you
8 have to do is passively breathe the medicine and it will
9 be absorbed in the lungs.
10 Q. How often was a nebulizer used with
11 Mr. Eastman while he was in the hospital?
12 A. A minimum of four times a day, but it could
13 have been five to six times a day.
14 Q. And how long would he wear the mask to do
15 that?
16 A. Ten minutes or so.
17 Q. And then when he got out of the hospital,
18 instead of the nebulizer was he given something else?
19 A. It's called an MDI inhaler.
20 Q. How does that work?
21 A. It's a little pressurized container where you
22 get a preset amount of medicine delivered. It's kind of
23 like the Primatene Mist that you see that you have to
24 coordinate your breathing with the activation of it,
25 then you actually hold it into your lungs. You have to
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1 hold your breathe for a period of time to increase the
2 time the medicine is in contact with the lung itself.
3 Q. Okay. How big -- is there a little cylinder
4 that it's attached to, maybe six or eight inches in
5 size, or is it smaller than that?
6 A. There is a spacer that sometimes people will
7 attach to it, but the MDI inhaler is typically about
8 three inches long.
9 Q. Was given several different medicines that he
10 had to inhale?
11 A. Two different medicines, Atrovent and
12 Albuterol.
13 Q. And was he also given a steroid?
14 A. He was given oral prednisone.
15 Q. And that he had to be weaned off of?
16 A. Correct.
17 Q. And why do you have to wean someone off of
18 Prednisone?
19 A. The only time you really have to wean someone
20 off is when they've been on it for a prolong period of
21 time to prevent withdrawal. In lung patients we tend to
22 a slow wean because the patient -- if the patient is
23 going to relapse, we hope to catch them when they're at
24 a less severe state as you gradually step down their
25 steroids on a day-by-day basis.
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1 So at least the philosophy is you gradually
2 take them down. If they start to relapse at that 30
3 milligrams where they were on 60 milligrams, you can
4 hold it there or increase it slightly and maintain them
5 at a slightly longer period of time to increase the
6 likelihood that they will recover.

7 Q. Is he given a dose -- excuse me. What did you
8 give him in term of milligrams per day?

9 A. I would have to look at that.

10 Q. Is it somewhere in the range of five to 20?

11 A. No.

12 Q. Less than that?

13 A. No. Somewhere in the range of 40 to 60. I
14 gave him 30 milligrams twice a days when he left, which
15 is 60 milligrams a day.

16 Q. Is that a fairly strong dose?

17 A. Yes.

18 Q. Does prednisone cause a person to have any
19 feelings, side-effect feelings?

20 A. There are many, many side effects, depending
21 upon the dose and how long you are on it. Acutely in
22 the short term it can increase the appetite and
23 therefore increase weight gain and the retention of
24 fluid. Psychologically, it can make them more agitated
25 or make them depressed or give them difficulty sleeping.

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1 It does have psychological effects. Long-term steroids,
2 if you put people on it and do not remove, it has a
3 tremendous amount of side effects.

4 Q. Now, the other medications that were given,
5 such as through the nebulizer while he was in the
6 hospital, what kind of effect do they have?

7 A. They have very minimal effects. Some
8 patients, since they are given an inhaler, the effects
9 are predominantly local and sometimes they can make
10 people kind of shaky and tremulous for a few, you know,
11 five to ten minutes after the administration.

12 Q. Was he given something other than Zolof to
13 help him sleep?

14 A. He was given ProSom at some point to help him
15 sleep, which is basically a sleeping aid. He was not
16 given it -- from my notes, was not given it at the time
17 of discharge but was given at it at a later time. I'm
18 not sure if he contacted my office before he came in,
19 but I don't have it dictated as one of the medicines I
20 wrote a prescription for. But by the time he showed up
21 to my office the first time, he was taking ProSom.

22 Q. Are boli a finding associated with emphysema
23 on x-ray?

24 A. Yes.

25 Q. What are boli?

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1 A. They are large areas of the lung that no
2 longer have any lung tissue. It's kind of like an empty
3 balloon.

4 Q. In reviewing the chest x-rays for
5 Mr. Eastman's June 10, 1995 admission, was there
6 evidence of boli that you either documented in the chart
7 or that the reviewing radiologist documented in
8 preparing the official radiology report?

9 A. No.
10 Q. In your review of the June 10, 1995 radiology
11 report, was there anything that you see in the official
12 interpretation that would be a classic finding for
13 emphysema?
14 A. No.
15 Q. Do you recall the series of questions that
16 Mr. Acosta asked you about the effects of smoke on the
17 cilia and the mucus production of the lungs?
18 A. Yes.
19 Q. If in fact smoking was having those effects in
20 a particular individual smoker, what symptoms would you
21 expect them to cause?
22 A. Well, the increase mucus production, increase
23 cough production of phlegm, which would be white or
24 discolored. Again, sometimes you would expect to see
25 increased susceptibility to infection, some more

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1 frequent exacerbations of acute bronchitis or even
2 pneumonias.
3 Q. Over the course of a period of, say, five to
4 ten years, if smoking was causing those kind of changes
5 in a smoker, how would you characterize the expected
6 clinical course with respect to the presence or absence
7 of a cough, the presence or absence of a productive
8 cough and symptoms of those or that nature?
9 A. Again, it depends upon the severity of the
10 problem. If they have symptoms, which not everybody
11 would. But if they had symptoms, it would probably be
12 an increased frequency of a cough.
13 Q. Are you familiar with any study that shows
14 that Zolofit actually has the effect of reducing the
15 smoker's craving for nicotine?
16 A. No.
17 Q. Are you aware of any study that has shown any
18 medical significance to the use of Zolofit that any
19 significant association with the ability of smokers to
20 quit?
21 A. No.
22 Q. You were asked about the single x-ray of
23 Mr. Eastman's chest that was done back on June 10 or so
24 of 95 and you were asked whether it demonstrated boli.
25 A. Yes, sir.

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1 Q. Can you tell us what boli is?
2 A. Again, it's a large area of open lung that's
3 really without any active lung tissue involved. So it's
4 like a balloon, just an air-filled pocket within the
5 lung.
6 Q. Are they always seen on x-ray?
7 A. No.
8 Q. So you can have boli without being able to see
9 them on x-ray?
10 A. Boli is typically a radiographic description,
11 so boli is typically what we describe radiographically
12 rather than any way. But x-rays are insensitive and
13 they may in the ability to detect -- are very
14 insensitive to the ability to detect COPD.
15 Q. Can you or do you as a lung physician diagnose
16 COPD, either chronic bronchitis or emphysema, from an
17 x-ray of a lung?

18 A. No.
19 Q. And what do you need? What's the diagnostic
20 criteria for chronic bronchitis or emphysema?
21 A. The way to make that diagnosis is by a
22 pulmonary function testing.
23 Q. Is that what you did in Mr. Eastman's case?
24 A. Yes.
25 Q. Are x-rays an insensitive tools for the

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1 diagnosis of COPD?
2 A. Yes.
3 Q. Is emphysema actually a pathologic diagnosis?
4 A. Yes. It's a pathology diagnosis. We infer
5 emphysema based on some x-ray, criteria some PFT
6 criteria. But emphysema itself is truly a pathological
7 diagnosis.
8 Q. And in this case, with respect to the x-ray
9 criteria in which you have in front of you, those
10 criteria don't exist in the x-ray, correct?
11 A. Correct.
12 (Whereupon, there was an interruption in the
13 reading the deposition testimony, as follows:)
14 MR. DENSON: That's the end.
15 MR. ACOSTA: Well, no. There's some more.
16 Page 142.
17 (Whereupon, the reading of deposition testimony
18 continued, as follows:)
19 Q. Is there such a thing as a clinical diagnosis
20 of emphysema and COPD?
21 A. Yes.
22 Q. Can you distinguish that from a pathologic
23 diagnosis?
24 A. Yes. Again pathologically speaking, you do.
25 You do see the destruction of the lung tissue itself.

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1 You can physically see it microscopically and sometimes
2 on gross pathology.
3 Clinically, you're inferring that the
4 destruction is there based upon the observed clinical
5 effects or testing that you have done to support the
6 changes in the physiology and function of a lung based
7 upon the testing that you've done that would be
8 explained by the pathology that would be seen at
9 postmortem examination.
10 Q. Is the clinical diagnosis considered a
11 standard in the medical profession?
12 A. Yes.
13 Q. And did you make a clinical diagnosis of
14 Mr. Eastman's chronic obstructive pulmonary diagnose?
15 A. Yes.
16 Q. And was his chronic obstructive pulmonary
17 disease of the type that has resulted from the
18 destruction of his lung tissue?
19 A. I don't have enough, but you're talking about
20 the gas exchange units. I don't have enough
21 information. He had a COPD pattern. There are certain
22 patterns that are more consistent with emphysema, but
23 they require lung volumes and diffusing capacities --
24 diffusing capacity to make that type of assessment based
25 upon.

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1 That's one reason as I -- when we started
2 talking at the beginning, I said we know group emphysema
3 and chronic bronchitis under one diagnosis for various
4 reasons. But he fulfilled the diagnosis as COPD, which
5 is the current thinking -- which the current thinking is
6 if you got COPD, you have -- you both have evidence of
7 pathologic diagnosis of both chronic bronchitis and
8 emphysema because one does not exist by itself in the
9 complete absence of the other.

10 Q. In Mr. Eastman's case then, based on the
11 visits you had with them ten days in the hospital and
12 then two follow-up visits, you didn't see or do any
13 further testing which would distinguish between the two
14 any further than what you've already testified about?

15 A. I've not seen any further testing. If he had
16 continued to follow-up with me, at some point we would
17 have repeat the pulmonary function test, because the
18 ones that were done in the hospital were done in a
19 fairly unstable, acutely ill state. And we would have
20 liked to have seen what his baseline was and completed
21 lung volume part of the pulmonary function test to
22 further characterize his disease.

23 MR. ACOSTA: That ends Dr. Tinsley's
24 deposition.

25 THE COURT: All right.

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1 MR. ACOSTA: And next we're hoping for a video
2 deposition of Dr. Bruchette.

3 MS. FAGGIANELLI: Your Honor, before we get
4 started with that, there is one issue that --

5 THE COURT: Approach the bench.

6 (Whereupon, the following proceedings occurred
7 out of the hearing of the jury:)

8 MS. FAGGIANELLI: Pages 115, 116 of
9 Dr. Burchette's deposition, there's testimony about
10 addiction and nicotine withdrawals. Dr. Burchett
11 is a general practitioner, a primary care
12 physician. Thus far on the record we have had to
13 testimony on addiction withdrawal from Dr. Jacobs,
14 Dr. Farone, Dr. Groff, Dr. Goldman and Dr. Tinsley.
15 This will be number six.

16 MR. LYDON: It's also kind of cumulative.

17 MR. ACOSTA: It's not, Your Honor. Every time
18 they ask questions about what did doctor --

19 THE COURT: Did he actually counsel the
20 plaintiff?

21 MR. ACOSTA: Yes, and he was within the first
22 11 months.

23 THE COURT: All right. I will permit it.

24 MR. ACOSTA: Thank you. It's only two pages.

25 The sound is not very good, but it's better

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1 than Dr. Tinsley's.

2 THE COURT: Do we need the lights adjusted?

3 MR. ACOSTA: We will when I find it on the
4 screen.

5 (Whereupon, the videotaped deposition testimony
6 of Robert B. Burchett, M.D. was played to the jury, as
7 follows:)

8 BY MR. ACOSTA:

9 Q. Dr. Burchett, Howard Acosta.
10 MR. ACOSTA: The sound is not that bad. We're
11 not getting the sound through that speaker. We are
12 getting it through the computer.
13 BY MR. ACOSTA:
14 Q. Dr. Burchett, I'm Howard Acosta and I
15 represent John Eastman. Have we ever met before today?
16 A. No.
17 Q. And before I ask you questions about your care
18 and treatment of Mr. Eastman, would you tell us where
19 you went to medical school and when you graduated?
20 A. I went to the University of Dominica in the
21 Caribbean, graduated in 1981. Did a three-year
22 residency at Washington University in St. Louis in
23 internal medicine, finished in 1984. And I've been
24 practicing since then in primary care, internal
25 medicine.

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1 THE COURT: I was going to say, this is
2 supposed to be the good audio.
3 MR. ACOSTA: This is the worse part of it and
4 it gets better. It has a couple bad parts. We can
5 read the answers to the few places where it's
6 difficult to hear him, which we will be happy to do
7 if they would like. Do you want to read the answer
8 to that question?
9 MR. PARRISH: I didn't hear the question, Your
10 Honor.
11 MR. ACOSTA: "And before I ask you questions
12 about your care and treatment of Mr. Eastman, would
13 you tell us where you went to medical school and
14 when you graduated?
15 Answer: "I went to the University of Dominica
16 in the Caribbean, graduated in 1981. Did a
17 three-year residency at Washington University in
18 St. Louis in internal medicine, finished in 1984.
19 And I have been practicing since then in primary
20 care internal medicine."
21 "And can you tell me a little bit about your
22 residency and then any post residency board
23 training or board certification or things like that
24 that you might have been involved in after 1981."
25 "Just the standard general internal medicine
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1 residency for three years and no training since
2 then. I am not board certified in internal
3 medicine."
4 MR. ACOSTA: Let me try to continue this.
5 (Whereupon, the playing of the videotaped
6 deposition continues, as follows:)
7 BY MR. ACOSTA:
8 Q. And can you tell me a little bit about your
9 residency and then any post residency training or board
10 certification or things like that that you have been
11 involved in after 1981?
12 A. Just the standard general internal medicine
13 residency for three years and no training since then.
14 I'm not board certified in internal medicine.
15 Q. Is there any particular reason why you're not
16 board certified?
17 A. I haven't passed the exam.

18 Q. Do you work with another physician currently?
19 A. Yes.
20 Q. And have you been since 1981?
21 A. Well, I graduated in '81. I was in residency
22 until '84.
23 Q. Okay. Since '84?
24 A. Yeah. I think I came -- I worked part time
25 for him originally in '85, I think it was. And I

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1 started and probably have been full time since about
2 '86.
3 Q. And have you been in Tampa since then?
4 A. Yes.
5 Q. And I take it you're licensed to practice
6 medicine in the state of Florida?
7 A. Yes.
8 Q. And you're licensed to prescribe drugs of all
9 sorts?
10 A. Yeah.
11 Q. And as an internist, what is the -- most of
12 the patients you see I take it are adults?
13 A. They are all adults.
14 Q. And --
15 A. Over the age of 12.
16 Q. And if they need specialized care, then you
17 would refer them out to another doctor?
18 A. Yes.
19 Q. Generally is your practice similar to a family
20 practitioner?
21 A. Yes, except we don't really see children or
22 heavy gynecology stuff. Otherwise, it's primary, pretty
23 primary care. Similar to a family practice.
24 Q. So in any event, back in May of 1996,
25 Mr. Eastman came to see you for the first time?

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1 A. Yes.
2 Q. And he filled out a questionnaire?
3 A. Yes.
4 Q. I would like to ask you some questions about
5 what was reported to you about Mr. Eastman at the time.
6 Do you take the information in the
7 questionnaire and use it as part of a history of the
8 patient?
9 A. Yes.
10 Q. And what is the purpose of taking a history?
11 A. To try to determine the problem at hand.
12 Q. Well, what was Mr. Eastman's chief complaint
13 when he came to see you?
14 A. Yeah. I'll say shortness of breath.
15 Q. And on the questionnaire, I believe that
16 indicates a series of questions regarding past history.
17 And it appears that there are a number of boxes after --
18 A. Could you refer to the page?
19 Q. -- illnesses. That would be page 0007?
20 A. Yes.
21 Q. Now, under past history at the very top.
22 THE COURT: Mr. Acosta, our court reporter is
23 unable to get some of this audio.
24 MR. ACOSTA: Well, I guess we could read it,
25 then, if that would be preferable. We have the

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1 deposition, which we can give her a copy so she
2 could transcribe it from the lines that were
3 designated for him.

4 THE COURT: Okay. Would the jury prefer to be
5 read or watched.

6 THE JURY: Read.

7 THE COURT: I guess they are having the same
8 trouble we are. It's hard to tell.

9 MR. ACOSTA: The sound goes and comes.
10 Sometimes it is better than it is at other times
11 and it's been about as bad as it gets. It doesn't
12 get any worse than it's been, but it does have
13 better spots in it. So that's all I can say on the
14 subject.

15 THE COURT: Well, it's just amazing in today's
16 technological world that we can't have a better
17 product than this. But I understand that
18 limitations sometimes exist.

19 MR. ACOSTA: I don't know how to explain it,
20 but it's what we have.

21 THE COURT: It's your evidence. However you
22 wish to proceed.

23 MR. ACOSTA: I think we will just try to go
24 ahead with it like this, unless it gets to the
25 point where nobody can hear it.

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1 (Whereupon, the playing of the videotaped
2 deposition continues, as follows:)

3
4 BY MR. ACOSTA:

5 Q. At the very top did Mr. Eastman check any of
6 the "no" boxes?

7 A. No.

8 Q. Did he check all of the "yes" boxes?

9 A. No.

10 Q. Does that mean he left some -- or many of the
11 boxes blank?

12 A. Yes.

13 Q. And how -- what is it, four "yes" boxes that
14 he checked out of 20 or so?

15 A. Yes.

16 Q. And then beneath that he had past operations,
17 which included testicular cancer in 1962 and then a
18 penile implant and then patella operation in 1984?

19 A. Yeah.

20 Q. Then on the next page there's a question that
21 says, "Have you ever smoked tobacco?" How did he
22 respond to that?

23 A. Yes. He put yes.

24 Q. And then the next question is, "Are you a
25 regular smoker now?" And how did he respond to that?

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1 A. He put no.

2 Q. And why is it that you ask patients if they've
3 ever smoked tobacco?

4 A. Because we think that smoking tobacco causes
5 chronic lung disease. Or may -- change -- may cause
6 chronic lung disease.

7 Q. And do you see patients regularly that come to
8 you with chronic lung diseases?

9 A. Yes.
10 Q. Do you see patients that come to you with a
11 disease called COPD?
12 A. Yes.
13 Q. And is COPD an acronym or initials that mean
14 chronic bronchitis, emphysema, or asthma?
15 A. It's made up of the combination of those,
16 usually a combination of all three of those to one
17 degree or another, yes.
18 Q. Okay. Asthma, though, would be -- is it a
19 separate disease from emphysema?
20 A. Yes.
21 Q. And is chronic bronchitis a separate disease
22 from either asthma or emphysema?
23 A. Yes.
24 Q. In Mr. Eastman's case, during the time that
25 you saw him from 1996 until 1998, did you ever determine

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1 what kind of COPD he had?
2 A. You mean whether predominantly chronic
3 bronchitis, predominantly emphysema?
4 Q. Yes.
5 A. I did not, no.
6 Q. Now, in the -- do you see patients that have
7 chronic bronchitis and/or emphysema on a regular basis?
8 A. Yes.
9 Q. Is cigarette smoking considered a significant
10 contributing cause of COPD?
11 A. Yes.
12 Q. And I believe that you took, in addition to
13 this smoking history of Mr. Eastman, somewhere in your
14 records was there an indication that he had
15 approximately a 100-pack-year smoking history?
16 A. I believe that's Dr. Modh's determination,
17 yeah.
18 Q. And that was one of the letters you signed off
19 on?
20 A. Yes.
21 Q. And a 100-pack-year smoking history would be
22 equal to two packs a day for 50 years?
23 A. Yes.
24 Q. Is that a significant amount of cigarette
25 smoking?

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1 A. Yes.
2 Q. Based on that smoking history and his
3 diagnosis of COPD, is it likely that Mr. Eastman's COPD
4 was caused by his cigarette smoking?
5 A. Yes.
6 Q. Now, we talked a little bit about his alcohol
7 consumption and past drug use. And he indicated in this
8 questionnaire at page 008 that -- the choices under
9 "Alcohol" involving beer was one bottle per day, two
10 bottles and then three or more; is that correct?
11 A. Yes.
12 Q. And I believe you said that he checked the two
13 bottles a day box?
14 A. Yes.
15 Q. And then when you asked him how much he was
16 drinking a day, I believe you said two to three; is that
17 correct?

18 A. Yes.
19 Q. Is two -- he didn't tell you he was drinking
20 three or more, did he?
21 A. No, he didn't.
22 Q. He said two to three. So would two to three
23 be what his statement to you was?
24 A. Yes. But it's not a choice here.
25 Q. Then under "Review of Systems" on page 009 of
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1 your records, which would be, again, the questionnaire
2 that he filled out when he first came to your office in
3 May of '96, it says under "General" -- can you tell us
4 what problems he had under the "General" review?
5 A. Well, he checked "Yes" for "Do you usually
6 feel tired or worn out?" That's the only one he checked
7 yes for.
8 Q. The one beneath that has a line through it.
9 A. Well, he crossed -- well --
10 Q. Through both of them?
11 A. For the question "Do you feel sad a lot of the
12 time?" he -- I don't know what that means. He put a
13 line through it. I don't know what to make of it.
14 Q. Did you question him as to whether he felt sad
15 a lot of the time?
16 A. I started him on antidepressant, and I note
17 that he had gone through a divorce recently. But I
18 guess I don't specifically have a comment about that.
19 Q. The question above it says, "Do you usually
20 feel tired or worn out?" Do you know how far back in
21 time he had been feeling tired, fatigued or worn out?
22 A. I don't know.
23 Q. This was a record of Dr. Tinsley?
24 A. Yes. But when he came -- you're asking was he
25 on it before only, right?

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1 Q. Yes. Was he on Zoloft before coming to see
2 you?
3 A. It looks like yes.
4 Q. And that is an antidepressant?
5 A. Yes.
6 Q. In looking at Dr. Tinsley's record under
7 "Assessment and Plan," the No. 1 assessment was COPD?
8 A. Yes.
9 Q. Then going back to 009, your intake
10 questionnaire, there's a question that says "Do you have
11 pain, tightness or pressure in the front or back of your
12 chest?" And he marked -- what did he mark for that?
13 A. He marked yes.
14 Q. And then the next question is, "If yes, is it
15 when walking fast, working hard or when excited?" And
16 how did he mark that?
17 A. He marked yes.
18 Q. Are yes answers to those two questions
19 consistent with COPD?
20 A. Yes.
21 Q. Now, if you look up above under his
22 occupational history, was he unemployed at the time or
23 not?
24 A. He has this time not a line, but he's checked
25 both yes and no.

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1 Q. Okay. And then you were asked some questions
2 about his hobbies and it said, "Have you discontinued
3 activities that were satisfying?" And he -- what did he
4 mark?
5 A. He put no.
6 Q. When was he hospitalized with the pneumonia?
7 A. I mean, I could probably answer that now. I
8 think I saw it -- here's a -- I don't know if you have
9 this or not. There's a discharge summary. It was
10 June 10 to June 20, 1995. I have a discharge summary
11 from Dr. Tinsley.
12 Q. Well, looking back now --
13 A. Yes.
14 Q. -- was there any hospitalization for pneumonia
15 after June of '95 through May of '96 when you saw him?
16 A. Not that I'm aware of.
17 Q. So then he would have been not smoking for how
18 long when you first saw him?
19 A. Eleven months.
20 Q. Let me ask you, have you counseled smokers to
21 stop smoking in the past?
22 A. Ad nauseam.
23 Q. And are you always successful in getting them
24 to stop?
25 A. No.

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1 Q. And why not?
2 A. I believe it's a very strong addiction.
3 Q. And with respect to that addiction, when a --
4 are there symptoms associate with stopping when someone
5 is addicted to smoking?
6 A. Yes.
7 Q. And they call it withdrawal symptoms?
8 A. Yes, withdrawal symptoms.
9 Q. Well, let me ask you this: When are the
10 withdrawal symptoms experienced by a smoker who has
11 stopped smoking?
12 A. Quickly, as you -- within hours to days after
13 stopping.
14 Q. Is it normal for someone to experience acute
15 withdrawal symptoms 11 months later?
16 A. With nothing in between you mean?
17 Q. Yes.
18 A. No. I mean, that's unusual, yeah. It's
19 unusual.
20 Q. It would be unusual. Would it have been
21 unusual for Mr. Eastman to still have withdrawal
22 symptoms 11 months later?
23 A. People still crave, I mean, crave smoking. To
24 answer your question, I guess it would be unusual, yes.
25 Q. Aside from the craving, would it be unusual?

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1 A. I'll say yes.
2 Q. Would there have been any need for Mr. Eastman
3 to get nicotine replacement therapy or any other aid at
4 the time you saw him 11 month after he had quit smoking?
5 A. No.
6 Q. Have you had patients in the past that have
7 stopped smoking during a hospitalization for a serious
8 or severe illness?

9 A. Yeah. They have to. I mean, you don't get a
10 choice.
11 Q. Why is that?
12 A. You can't smoke in the hospital. I mean, they
13 would have to -- especially at an intensive care unit or
14 something. I suppose they could get around it if they
15 were -- you know, they could go outside or something to
16 smoke.
17 Q. And did Mr. Eastman -- well, let me ask you.
18 What is the significance of your statement "he stopped
19 seven month ago when he was hospitalized with severe
20 pneumonia" in terms of his stopping, if anything?
21 A. What significance does it have? Time to date
22 his -- when it was, and it's a somewhat believable
23 situation to stop smoking.
24 Q. And what makes it somewhat believable in his
25 case?

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1 A. Well, because you can't smoke in the hospital,
2 I mean, basically. People become -- patients become
3 more teachable about smoking when they have an illness
4 related to it or possibly related to it. They are more
5 -- they are at a teachable moment. They can -- they are
6 more likely to respond to stopping when something --
7 when they can see a relationship.
8 Q. Is a person on oxygen permitted to smoke?
9 A. No. No.
10 Q. Why not?
11 A. Because the oxygen is combustible. It could
12 cause an explosion.
13 Q. Then you indicate when you first saw him that
14 he had shortness of breath and dyspnea on exertion.
15 What did you mean by that?
16 A. Dyspnea on exertion is shortness of breath
17 when he exerts himself. When he tries to do things, he
18 exacerbates his breathing.
19 Q. Is there a difference between dyspnea and
20 shortness of breath?
21 A. No. But I think I'm trying to say that
22 shortness of breath would be, you know just short of
23 breath all the time as opposed to dyspnea on exertion.
24 Maybe that's the distinction I'm trying to make, if any.
25 Q. Yeah, because it says, "Since then he had

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1 shortness of breath and dyspnea on exertion." So what
2 I'm trying to figure out is what you meant by including
3 both phrases in that sentence?
4 A. I don't know, but I could take it to mean that
5 he's short of breath at rest.
6 Q. And then what do you say next?
7 A. He cannot walk up a flight of stairs without
8 getting short of breath or walk long distance without
9 resting.
10 Q. Was there any other history that he gave you
11 that is significant in your mind to his shortness of
12 breath or dyspnea?
13 A. No.
14 Q. Then you formed a diagnosis on that first
15 visit in May of 1996?
16 A. Yes.
17 Q. And what was your diagnosis?

18 A. Chronic obstructive pulmonary disease.
19 Q. And then one of the items under your plan is
20 for him to take inhalers and Zolof; is that correct?
21 A. Yes.
22 Q. Another is for him to lose weight. It appears
23 that he's six feet at 215 pounds.
24 A. Yes.
25 Q. How much weight did you think that it would be

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1 good for him to lose?
2 A. Maybe 20 pounds; 20, 30 pounds.
3 Q. Now, someone with COPD, do they -- does COPD
4 cause them to be real sedentary due to their shortness
5 of breath?
6 A. Yes.
7 Q. Is gaining weight a symptom of smoking
8 abstinence or smoking cessation?
9 A. It can be, yes.
10 Q. How significant, if at all, was Mr. Eastman's
11 weight at 215 at six feet tall?
12 A. It's another factor. I get less worried about
13 obesity in people with chronic lung disease because they
14 tend to lose weight just from their disease alone over
15 time. In fact, we tend to augment their diet further
16 on.
17 Q. Did you anticipate that he would eventually
18 continue to lose weight?
19 A. Yes.
20 Q. Then if you would, turn to 0021. That would
21 be the lab results of about ten weeks later after your
22 first visit; is that right?
23 A. Yes.
24 Q. And I see one of the criteria with a circle
25 around it, and it says "Good" with an exclamation point?

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1 A. Yes.
2 Q. And what was meant by that?
3 A. That was just that he had good HDL, the
4 so-called protective cholesterol. Good in the face of
5 his otherwise -- I think his total cholesterol was high.
6 Q. There's an LDL right under it.
7 A. LDL is bad. At that time -- when is this,
8 '96? My criteria for good, I might not have circled
9 good nowadays. That's changed. But back then, yes, I
10 thought that the HDL was protective on -- I don't see --
11 oh, here is his total cholesterol, 271, was high.
12 Q. Now, did he have any what you would consider
13 to be abnormal findings on his laboratory work in August
14 of '96?
15 A. Well, he had high lipids, high LDL, high total
16 cholesterol, slightly high triglycerides. But he also
17 had this somewhat protective HDL. I mean, it was --
18 Q. So was it anything that you were significantly
19 concerned about?
20 A. He should be on a low fat diet like everybody
21 else. I wasn't treating it with medication, if that's
22 what you --
23 Q. Okay. When people are chronic abusers of
24 alcohol, do you see laboratory indications of that?
25 A. You can.

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1 Q. And what would you usually see if someone was
2 chronically abusing alcohol?

3 A. Well, liver function abnormalities, liver
4 function test abnormalities, which he does not have.

5 Q. Okay.

6 A. And you can see -- in my experience and I
7 think others' experience, the MCV, one of the -- the
8 size of the red blood cells get bigger in kind of closet
9 alcoholics and people who -- and not just closet
10 alcoholics, just alcoholics in general because they are
11 not getting the -- I guess the theory is that they're
12 not getting the nutrients to build the red blood cells.
13 He does not have that. There's other things like that,
14 I mean. But they are not hard and fast, and you don't
15 have to have them. But he doesn't have them.

16 Q. Okay. Well, so he -- does he have any
17 indications on his lab work that would suggest to you
18 that he was a heavy drinker?

19 A. No. I would say no.

20 Q. Okay.

21 A. That doesn't mean he's not. But he doesn't
22 have -- to answer your question, no, he does not.

23 Q. Well, based on the things that he told you and
24 based on your examination and based on his visits and
25 based on his lab work, did you have any indication that

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1 he had any problem with alcohol?

2 A. I mean, he keeps stating that he's drinking.
3 I don't know if that's a problem. He says that he
4 drinks, you know, all through here. Most of the way
5 through he said he drinks two, three, four beers.

6 Q. Okay.

7 A. Is that a problem? I don't know.

8 Q. That's what I'm trying to find out. Did you
9 diagnose any problem yourself with alcohol?

10 A. I was more worried about his breathing, but I
11 don't consider that terrible, no. I would rather he
12 didn't do it, but --

13 Q. How about a couple drinks; is that okay?

14 A. I would say a couple drinks is okay.

15 Q. And you mentioned that all through here --
16 well, I'm going to go through those because at one
17 point you were asked a question.

18 Why don't we go to 0040. That's March of '97.
19 Under "Social history" it indicates social alcohol.

20 A. Yes.

21 Q. If -- and was this a report that was taken by
22 another physician in your office?

23 A. A medical student.

24 Q. If there had been a problem, is that medical
25 student trained to put something other than social

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1 there?

2 A. Yes.

3 Q. Is social alcohol considered generally to be a
4 problem?

5 A. No.

6 Q. And then the next visit was on 0041. And
7 that, again, is a report made by a resident that's
8 working with you?

9 A. Yes.
10 Q. In fact, the one that I just mentioned, 0040
11 and 0041, you signed off on those, right?
12 A. Right. Well, but as we determined earlier,
13 the one from 4/24/97 was actually -- that corresponds to
14 Dr. Rosenthal's dictation that's 0044.
15 Q. Okay.
16 A. I think I signed off just because there was no
17 -- nobody signed off later on when we go through the
18 records. Probably when -- probably when you requested
19 the record or you guys requested the records, I probably
20 saw that no one had signed off on it and signed it.
21 Q. So you signed it?
22 A. So I signed it.
23 Q. All right. Well, for "Social History" there
24 it says --
25 A. But I did not see him that day, I guess.

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1 Dr. Rosenthal saw him.
2 Q. Okay. Well, up there it says, on that record
3 of April of '97, it says "occasional alcohol;" is that
4 right?
5 A. Right. Yes.
6 Q. Is occasional alcohol the same thing as social
7 or is it less or what does that mean?
8 A. I would take it to mean less. It's not that
9 specific. It's not suggestive of a drinking problem, if
10 that's what you're --
11 Q. Okay. And then I notice that you dictated
12 this report in your office notes on 0044. Does that --
13 that pertains to that particular visit?
14 A. Yes. That correspondence to that visit, yes.
15 Q. Does it indicate there's any alcohol -- even
16 any alcohol use in the narrative --
17 A. I think it just --
18 Q. -- narrative report?
19 A. -- isn't mentioned one way or the other.
20 Q. Okay. Then we -- you were asked about 0073,
21 which is a report about -- I guess that's about --
22 A. This is from Dr. --
23 Q. -- a year later.
24 A. March of '98.
25 Q. Is that about a year after the -- it's 11

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1 months after the '97 visit that we just discussed?
2 A. Yes, it is.
3 Q. And that's 0073?
4 A. That was April '97 versus this is March '98.
5 Q. And this is a letter to you from a Dr. Modh
6 who was a pulmonary or a lung doctor?
7 A. Yes.
8 Q. Did Mr. Eastman, after you saw him in May of
9 '96 up through April of '97, ever report more than two
10 or three or three or four beers a day?
11 A. No.
12 Q. And then in March of '98, approximately 11
13 months later, it indicates that he is drinking less than
14 before; is that correct?
15 A. That's correct.
16 Q. So in any event, at any time did you diagnose
17 any disease that you felt was caused by any alcohol

18 consumption on the part of Mr. Eastman?
19 A. No.
20 Q. Did you at any time feel that he had any
21 significant problem from drinking two or three drinks a
22 day?
23 A. No.
24 Q. And in terms of it might have helped him to
25 feel better if he didn't drink at all, in what sense

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1 might it have helped him to feel better if he didn't
2 drink at all?
3 A. Again, I'm not encouraging him to drink. I
4 don't know how to answer this.
5 Q. Well, I believe there's --
6 A. I would rather he didn't drink, period. I
7 don't have a problem with small amounts of alcohol.
8 Q. In what sense, if at all, would not drinking
9 at all would have helped him?
10 A. I guess I don't share Dr. Modh's insistence on
11 decreasing -- on -- I mean, I would like him to decrease
12 the alcohol. Nutritionally, it's not the best thing. I
13 mean, kind of common sense things. I don't know how to
14 directly answer it.
15 Q. Did it have anything --
16 A. What is your question? What was your original
17 question?
18 Q. Did the alcohol have anything to do with his
19 chronic obstructive pulmonary disease?
20 A. I'll say directly, no.
21 Q. Can a person lose a lot of capacity from a
22 chronic disease and if they have a sedentary lifestyle
23 not know it until some dramatic event?
24 A. Simple answer: Yes.
25 Q. And why is that?

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1 A. Well, because we -- there's a reserve ability
2 of the lungs to work that you may never be called upon
3 to use until you exert yourself. And a sedentary person
4 may never discover it until they do something. And as
5 you age, you're losing alveolus and things. I mean,
6 it's a cumulative, chronic process.
7 Q. The alveolus that you're talking about, those
8 are the air sacs?
9 A. Little air sacs, yeah.
10 Q. And based upon your knowledge and training,
11 are those lost in someone that has emphysema?
12 A. Yes.
13 Q. Do you remember seeing in your records a
14 reference to a diagnosis of emphysema with respect to
15 Mr. Eastman?
16 A. You mean specific emphysema? These terms are
17 thrown around, you know, broadly.
18 Q. Look at --
19 A. Technically chronic obstructive lung disease
20 is not just emphysema.
21 Q. I understand. If --
22 A. Are you going to show me somewhere?
23 Q. Yeah. Dr. Modh's letter to you of October
24 '96, which is 0038.
25 A. Yes.

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1 Q. All right. In the first paragraph --

2 A. "Probably has emphysema."

3 Q. Do you normally determine things on the basis
4 of probability in terms of making your diagnosis?

5 A. Yes.

6 Q. Let me read it to you. It says, "He has
7 undergone PFT, which shows that the patient has only
8 about 37 percent FEV1 with sever obstructive lung
9 disease."

10 Is emphysema a sever obstructive lung disease?

11 A. It is.

12 Q. Can you explain what 37 percent of FEV1 is
13 with respect to Mr. Eastman?

14 A. That he's only able to do -- I mean, you could
15 look at it the way that you just interpreted it, only 37
16 percent of what a normal person could blow out in one
17 second.

18 Q. And then it says, "There is some change after
19 broncodilators and also has a significant reduction in
20 diffusion capacity." Now, what is diffusion capacity?

21 A. Diffusion capacity, to my knowledge, is the
22 ability of the alveolus to exchange gases from the
23 bloodstream into the -- into the lung.

24 It's destroyed in emphysema as opposed to
25 chronic bronchitis. It's technical jargon and a

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1 technical test to try to determine the different kinds
2 of lung diseases that make up chronic obstructive lung
3 disease.

4 Q. With a 37 percent FEV1 and a significant
5 reduction in diffusion capacity, would you agree with
6 Dr. Modh where he is "suggesting that patient probably
7 has emphysema associated with this"?

8 A. I would agree. He's a pulmonologist.

9 Q. And if you look at 0036, which is -- would you
10 tell us what that is?

11 A. This is a report by a radiologist of a chest
12 x-ray from October 1996.

13 Q. And does that correspond with Dr. Modh's visit
14 in October of '96 in some way?

15 A. Yes.

16 Q. And what did the radiologist look at?

17 A. He interpreted it as signs of emphysema is
18 what he -- is his final conclusion.

19 Q. And your signature on this?

20 A. Yes.

21 Q. It says "Date Reviewed, 10/15/96"?

22 A. Yes.

23 Q. And what kind of a disease is emphysema in
24 terms of its prognosis or future effect?

25 A. It's a continually destructive disease to the
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1 alveolus, to the breathing air sacs, and accumulation of
2 stale air in the lungs that can't be exchanged, can't
3 get re-exchanged because the alveoli are no longer
4 working as they used to.

5 Q. Does it -- does it cause impairment?

6 A. It causes shortness of breath. Gradual,
7 progressive.

8 Q. Until what?

9 A. Until death. I mean, slow. Slowly. It
10 doesn't -- it's not quick.
11 Q. Is emphysema a fatal disease?
12 A. It's a fatal disease.
13 Q. Oh, do inhalers cure emphysema?
14 A. There's no cure for emphysema, so no.
15 Q. Well, tell me, was Mr. Eastman on any lung
16 medication when he first came to see you?
17 A. According to my notes, he was not.
18 Q. Did he come to see you to get refills or to
19 get new lung medication?
20 A. Yes.
21 Q. And so, did you prescribe for him some
22 inhalers of medications to help him breathe?
23 A. Yes.
24 Q. And so did you prescribe for him some inhalers
25 of medications to help him breath?

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1 A. Yes.
2 Q. Well, let me ask you: Did you use them in the
3 manner in which you hoped he would use them?
4 A. No.
5 Q. And what happened in that respect?
6 A. What happened? He became worse.
7 Q. Are they easy to use?
8 A. No.
9 Q. Why aren't they easy to use?
10 A. It takes eye-hand coordination that people
11 typically don't have. There's several reasons.
12 Q. Initially, he was prescribed the inhalers to
13 use them so many time a day; is that right?
14 A. Yes.
15 Q. Well, did you ever tell him he could use them
16 as needed?
17 A. Probably.
18 Q. Why did it get to the point where you told him
19 that he could simply use the inhalers when he wanted to?
20 A. I mean, that's not what Dr. Modh has done, but
21 there's places where I guess I did. And -- because it's
22 never been proven that inhalers -- that they even help,
23 that they may necessarily help for people with chronic
24 lung disease as opposed to asthma. They definitely help
25 with asthma. They may or may not do some good for

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1 people with chronic lung disease or emphysema.
2 Q. And those that have chronic lung disease like
3 emphysema, do they have permanent destruction of the
4 tissues?
5 A. Right.
6 Q. Does the inhaler --
7 A. It has no place --
8 Q. -- restore it in any way?
9 A. No. But it can -- I mean, this is a very
10 difficult question that you probably don't want to go
11 into right now, but COPD is a combination of -- there
12 can be an asthmatic component. You know, people have
13 various components, asthma, chronic obstructive lung
14 disease and emphysema. So you try to treat what you
15 can.
16 Some respond more to bronchodilators than
17 others do. So that's why I may not -- I may not have

18 been pushing it like it sounds like Dr. Modh did push it
19 more than me.

20 Q. So what I'm trying to figure out is where do
21 they fit then if they are not a cure and they are not
22 palliative, what would -- what do they do for somebody
23 like him?

24 A. Okay. This is me speaking. Chronic
25 obstructive lung disease, other than getting -- I think

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1 I said it earlier, other than getting people to stop
2 smoking, there's not a lot of things proven that can
3 really help them. And so we do what we can do of the
4 available things. And some people have a better
5 response to bronchodilators than others do. So we just
6 kind of throw -- I mean, at least -- I shouldn't say we
7 -- I try to treat whatever I can treat or possible
8 treat, especially in a disease that's fatal that has no
9 cure.

10 MR. ACOSTA: That would be the final portion
11 of this deposition.

12 THE COURT: All right. I believe I have
13 received a request from one of the jurors to start
14 at 8:30 tomorrow. Are there some of you who would
15 like to start at 8:30 tomorrow? Don't be shy. We
16 can certainly start at 8:30 if you would like. If
17 that doesn't work for somebody. Is there anybody
18 who cannot start at 8:30 tomorrow?

19 THE JURY: Fine (collectively).

20 THE COURT: This okay with everybody?
21 Actually, it might be better to start at 8:30 and
22 get more in the morning; although, we are on
23 schedule. So I know that it sometimes seems
24 tedious, but we are coming -- I think the plaintiff
25 was planning on concluding plaintiff's case in the

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1 next few days. All right. Well, we will see you
2 all at 8:30 tomorrow morning. Thank you very much.

3 (Whereupon, the jury left the courtroom.)

4 THE COURT: Well, I volunteered you for 8:30
5 tomorrow. Are you going to be ready to go?

6 MR. ACOSTA: I think we can handle it.

7 THE COURT: Here is a cryptic note, 8:30.
8 Perhaps I should have assumed they wanted to go
9 until 8:30 tonight. You are a student of body
10 language.

11 Okay. Is there anything else we need to do to
12 get ready for them at 8:30 tomorrow?

13 MR. ACOSTA: I don't think so.

14 THE COURT: Is the defense going to be reading
15 or playing that?

16 MR. LYDON: We will be reading, Your Honor.

17 MR. ACOSTA: I probably need to finish couple
18 more lay depositions, publish some documents and
19 publish Dr. Heiman's deposition and then it's
20 possible I may get to Mr. Eastman in the afternoon
21 sometime. Probably will start Wednesday at 8:30
22 with Mr. Eastman.

23 MR. PARRISH: We are still waiting for a copy
24 of the Heiman deposition. I would like to see that
25 deposition before it's put on.

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1 MR. ACOSTA: It's crashed on the computer last
2 night, so we have to reload it tonight and we can
3 redeliver that document.

4 THE COURT: Okay. Very good. Let's be ready
5 to go at 8:30 tomorrow. Be here before that.

6 THEREUPON, the trial concluded sine die.
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1 REPORTER'S TRIAL CERTIFICATE

2 STATE OF FLORIDA)
3 COUNTY OF PINELLAS)
4

5 I, TONYA HORNSBY-MAGEE, Registered Professional
6 Reporter, certify that I was authorized to and did
7 stenographically report the trial of the foregoing
8 proceedings; and that the transcript is a true and
9 complete record of my stenographic notes.
10

11 I FURTHER CERTIFY that I am not a relative,
12 employee, attorney, or counsel of any of the parties,
13 nor relative or employee of such attorney or counsel,
14 nor financially interested in the outcome of the
15 foregoing action.
16

17 Dated this 25th day of March, 2003, at
18 Clearwater, Pinellas County, Florida.
19
20
21
22

TONYA HORNSBY-MAGEE, RPR

23
24
25
ROBERT A. DEMPSTER & ASSOCIATES